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ABSTRACT

It is indicated that the workshop was prompted by uneasiness among nurses about the impact of what they were doing (including the detection of symptoms as psychosomatic or real) by their requests for aid in improving their interviewing and counseling skills. The report states that the emphasis was on modern concepts in psychiatry and psychiatric nursing and in supervised field experience with school-age children. There are five chapter divisions. Chapter I is the introduction. Chapter II contains information on the workshop participants. Chapter III is a condensation and summary of the proceedings of the first workshop. Topics covered in this chapter include the concept of mental health, the concept of anxiety, the child and sex, and the child and death. The chapter also describes the field experience of the participants with material from the reports they were asked to compose. Chapter IV covers advanced workshop proceedings in which the focus was shifted from the normal child to the child with a serious emotional disturbance; participants' reports are again referred to; many of the topics in chapter III are repeated. Chapter V is on the evaluation of the workshops, with conclusions and recommendations. Included as appendixes are various correspondence, participant, and evaluation data from the workshop. (JA)

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# MENTAL HEALTH AND THE WORK OF THE SCHOOL NURSE

## A Report On A Series Of Workshops 1964-1969

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which exist at the summation of an enterprise.

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Elizabeth C. Stobo
Training Program Director

# TABLE OF CONTENTS

CHAPTER — PAGE NUMBER

I INTRODUCTION 1
Period of the Grant . . . . . . . . . . . . . . . . . . . . 2
Content of the First Workshop . . . . . . . . . . . . . . 2
Response of the Participants . . . . . . . . . . . . . . 2
Content of the Advanced Workshop . . . . . . . . . . . . 3
Recruitment of Participants . . . . . . . . . . . . . . . 4
Teaching Staff . . . . . . . . . . . . . . . . . . . . . 4
Resource Materials . . . . . . . . . . . . . . . . . . . 6
Field Agencies . . . . . . . . . . . . . . . . . . . . . 6
Plans for Follow-up of Participants . . . . . . . . . . 9

II WORKSHOP PARTICIPANTS 11
Geographic Distribution . . . . . . . . . . . . . . . . 11
Age . . . . . . . . . . . . . . . . . . . . . . . . . . 11
Marital Status . . . . . . . . . . . . . . . . . . . . . 11
Educational Background . . . . . . . . . . . . . . . . . 11
Work Experience . . . . . . . . . . . . . . . . . . . . 13
Present Positions . . . . . . . . . . . . . . . . . . . 15

III WORKSHOP I: CONDENSATION AND SUMMARY OF PROCEEDINGS 18

PART I

Schools of Psychiatry . . . . . . . . . . . . . . . . . 18
Concept of Mental Health . . . . . . . . . . . . . . . . 19
Concept of Anxiety . . . . . . . . . . . . . . . . . . . 20
Growth and Development . . . . . . . . . . . . . . . . . 25
Communication . . . . . . . . . . . . . . . . . . . . . 37
Discussions with the Psychiatrist . . . . . . . . . . . 43
Large Group Discussions . . . . . . . . . . . . . . . . 46
Educational Films . . . . . . . . . . . . . . . . . . . 48

PART II

Field Experience . . . . . . . . . . . . . . . . . . . . 51

IV ADVANCED WORKSHOP: CONDENSATION AND SUMMARY OF PROCEEDINGS 81

PART I

Recordings of School Nurse-Student Interactions . . . . 81
Evaluating the Nurse-Student Interaction . . . . . . . 99

CHAPTER PAGE NUMBER

IV PART II
Primary and Secondary Process Thinking . . . . . . . . . 100
Mental Mechanisms . . . . . . . . . . . . . . . . . . . 101
Treatment Modalities . . . . . . . . . . . . . . . . . . 106
Crisis Intervention . . . . . . . . . . . . . . . . . . 110
Consultation . . . . . . . . . . . . . . . . . . . . . . 111
Discussions with the Psychiatrist . . . . . . . . . . . 114
The Role of the School Nurse in Mental Health . . . . . 121
Educational Films . . . . . . . . . . . . . . . . . . . 122

PART III
Field Experience . . . . . . . . . . . . . . . . . . . . 124
Other Learning Activities Utilized in the
Advanced Workshops . . . . . . . . . . . . . . . . . 126

V EVALUATION OF THE WORKSHOPS 131
Evaluation by Participants . . . . . . . . . . . . . . . 131
Supervisors' Evaluation of Participants' Performance . 138
Summary . . . . . . . . . . . . . . . . . . . . . . . . 144
Recommendations . . . . . . . . . . . . . . . . . . . . 145
Conclusion . . . . . . . . . . . . . . . . . . . . . . . 147

APPENDIX

A CORRESPONDENCE . . . . . . . . . . . . . . . . . . 149-159

B WORKSHOP SCHEDULES . . . . . . . . . . . . . . . . 160-163

C TABLES . . . . . . . . . . . . . . . . . . . . . . 164-182

D DATA GATHERING INSTRUMENTS . . . . . . . . . . . . 183-197

E INSTRUCTIONAL MATERIALS . . . . . . . . . . . . . 198-203

BOOKS, PAMPHLETS and PERIODICALS . . . . . . . . . . . . . . . 204-218

# Chapter I

# INTRODUCTION

The opportunity for promotion of mental health and the prevention of mental illness occurs in various community facilities and institutions far removed from those specifically designed for the care and treatment of mentally ill individuals. Dr. Milton J. Senn had this in mind when he wrote in 1965:

> It is not surprising that nonpsychiatric physicians, especially pediatricians, nurses, and hospital administrators, failing to understand the relationship of early life experiences to emotional development and behavior, often have been unable to see the influence of their roles in child care in promoting mental health .... (1)

Nurses who work in schools have become increasingly concerned about the influence of their nursing services. They have also become more acutely aware of the large number of children they see who have symptoms that appear to be of psychosomatic origin. The common complaint of headache or stomach ache often seems to arise from anxiety in a stressful situation. Some children appear to use a physical symptom, real or imaginary, as a means of access to the nurse. A child may enter the nurse's office with a complaint of a minor injury or an undefined illness and it soon becomes evident that his real concern is with another, more basic problem. He uses the initial symptom as a wedge to open the door to help with his real worries.

Nurses express concern, even uneasiness, about what they could be doing -- and should be doing in response to these covert pleas for help. They ask for aid in improving their interviewing and counseling skills. They express a desire to become more skilled in working with children and children's families. They wish to become more effective in intervention to avert difficulty, whether the presenting problem is subtle and undefined or patently verging on the pathological.

In response to these frequently expressed needs for help, a plan for a series of workshops for school nurses emerged. A proposal for a project that would include a 2-week workshop each year for five years was submitted to the National Institutes for Mental Health for approval and funding, both of which were granted.

The purposes of the workshops, as stated in the proposal, were:

1. To provide nurses, serving the schools, with learning activities based on modern concepts in psychiatry and psychiatric nursing which will increase the nurses' competence in working in the school.

2. To identify the skills the nurse in the school health program needs in order to function effectively in the prevention and treatment of emotional disturbances through systematic feedback and evaluation of the nurses' experience in the program provided.

## Period of the Grant

The project was designed to extend from July 1, 1964 to June 30, 1969. In each of the five years, funds were provided for the participation of 20 nurses in each workshop. To allow sufficient time for planning and preparation, the first of these workshops was not held until June, 1965.

## Content of the First Workshop

The content of the first workshop is described in detail in Chapter III of this report. Briefly, it included theories related to growth and development, communication, human behavior, and psychiatric nursing. A supervised field experience with school-age children was provided and participants were asked to keep process recordings of these nurse-child interactions.

## Response of Participants

The response of the participants to the first workshop was overwhelmingly positive. In fact, they requested that the workshop staff offer a second, more advanced workshop the following summer. This enthusiasm led to a request for additional funds from NIMH for conducting a second, more advanced workshop. The request was granted and the entire project was then altered to provide four series of workshops, each series consisting of a beginning 2-week session followed by an advanced 2-week workshop the following summer. The sequence of workshops and number of students in attendance were as follows:

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Workshop I | June | 1965 | 20 | Students | Workshop I-2 | July | 1966 | 11 | Students |
| Workshop II | " | 1966 | " | " | Workshop II-2 | " | 1967 | 17 | " |
| Workshop III | " | 1967 | " | " | Workshop III-2 | " | 1968 | 17 | " |
| Workshop IV | " | 1968 | " | " | Workshop IV-2 | " | 1969 | 19 | " |

The lowest number of returnees occurred in the workshop held in July, 1966. Because it was not known until late spring whether or not funds for the advanced workshop would be approved, some nurses who might have attended had already made local commitments. In addition, one prospective participant's mother became critically ill; a strike on a major airline left one stranded on the West Coast with her bags packed; and still another, stimulated by the first workshop, had decided to enroll for full graduate study.

## Content of the Advanced Workshop

The nurses who attended the first workshop desired to apply their new learning in their respective positions and then return to discuss some of the challenges and accomplishments that had resulted from this application. To help them in applying the knowledge and skill they had acquired in the first workshop, the nurses were each asked to keep a process recording of an interaction with a child in their respective schools. These recordings were reviewed by the workshop instructors. Individual conferences were arranged during the advanced workshop to discuss each student's work as revealed by the process recording she had submitted.

Nurses who had attended the first workshop also requested additional information about communication and the counseling process. They felt they needed this to help them understand and deal with crises and stress periods in children's lives. In addition, the instructors had observed evidence of a need for most of the nurses to develop more security and sophistication in their work with troubled children and families. For these reasons, time was allocated in the advanced workshop for participants to learn more about the manifestations of psychopathalogy in children and the ways of dealing with deviant behavior.

## Recruitment of Participants

The training program director initiated recruitment for the workshops by contacting various school nurses, school nurse supervisors, and others active in the field of school health who were known to her. They were asked to list the names of practicing school nurses with at least a baccalaureate degree who they thought might be interested in attending the workshop. Personal letters of invitation were sent to those nurses who were recommended (see Appendix, pp. 149-59 ff. for sample of all letters sent during the course of the workshop). Among the 80 people who attended at least one of the workshops were representatives from nearly half of the states in the United States.

## Teaching Staff

In addition to the project director who is a full-time faculty member at Teachers College, Columbia University, the principal investigator of a concurrent project dealing with the school nurse and mental health was released from that position during the summer months in order to teach in the workshops. These two permanent members of the teaching staff participated in each of the eight workshops. The project director is the faculty advisor for students at

Teachers College who are interested in preparing for school nurse positions. She has a background of preparation in public health nursing with a major interest in school health nursing. The second instructor has a background of preparation in psychiatric, mental health, and public health nursing.

Two additional nurses were employed as instructors for the first workshop in each pair in the series. Their major preparation was as follows:

Workshop I: Both instructors had preparation in both public health and psychiatric nursing.

Workshop II: One instructor had preparation in psychiatric nursing; one had preparation in child psychiatry.

Workshop III: The two instructors who had participated in the second workshop returned for the third one.

Workshop IV: The instructor with a background in psychiatric nursing returned (for a third year) and the second instructor had a background in child health and school nursing.

The instructors in the advanced workshops were as follows:

Workshop I-2: The two permanent members of the workshop teaching staff carried the major teaching responsibilities because of the small number of participants.

Workshop II-2: A psychiatric nurse was added to the teaching staff. This instructor was given released time for the 2-week period from her supervisory position at Psychiatric Institute (the agency which cooperated with the project in providing field experience for workshop participants).

Workshop III-2: A psychiatric nurse who was carrying postgraduate work at another university and was employed part-time at Psychiatric Institute joined the two permanent instructors.

Workshop IV-2: The two permanent instructors carried the teaching responsibilities for the final workshop in the series.

A psychiatrist participated in the lectures and discussions in each of the eight workshops. During Workshops I and II, the same psychiatrist was present. When personal plans did not permit him to return, a successor joined the teaching staff for Workshops III and IV. The same psychiatrist participated in the advanced workshops for each of the four years.

In general, there was a high degree of continuity in the teaching staff and similarity in the content offered.

## Resource Materials

The original grant provided for the purchase of books and reference materials specifically for the workshops (see Appendix, pp. 204-18 for bibliography of available materials). Approximately 140 books as well as numerous pamphlets and periodicals were kept in the room in which the workshop discussions were conducted. They were available for use by the participants at any time during the workshop sessions and could be borrowed for overnight use. The immediate accessibility of the resource materials seemed to promote rather extensive reading on the part of the students.

## Field Agencies

Two different hospitals were used as field centers for the workshops. Babies Hospital at The Columbia Presbyterian Medical Center, and Psychiatric Institute which is a part of the Medical Center complex. The cooperation of the staff members of these two institutions can best be described by the word "outstanding."

Babies Hospital is a 227-bed voluntary facility which is a part of the Columbia Presbyterian Medical Center. It is designed for the general medical and surgical care of children up to the age of thirteen years. Facilities are also provided for research and for the education of various medical, nursing, and ancillary personnel who participate in the care of children. The medical staff also maintains an outpatient department for children in another part of the Medical Center.

Educational services for school-age children are provided within Babies Hospital through the New York City educational system which assigns two elementary-school teachers to this location. Indoor and outdoor play areas are readily accessible. Playrooms for convalescent children are located on the seventh floor. There is also a specially equipped playroom on the fifth floor for children with orthopedic problems. Recreational therapists direct play activities and teach simple crafts in the ward solaria and at the bedside. Television and radio are provided in all children's wards. Construction of an addition to the hospital began in 1966. The new facilities will provide for the care of children in private and semiprivate rooms. Renovation planned for the present building will provide an enlarged and improved neonatal intensive care nursery, a new x-ray suite, a medical intensive care unit, an adolescent unit, an isolation unit, and other special facilities. The hospital maintains an active volunteer program to aid in making the children's period of hospitalization as pleasant as possible.

Students in the workshop visited children who were patients in various parts of the institution, chiefly those on general medical, surgical, orthopedic, and genitourinary services.

Psychiatric Institute is a tax-supported public institution operated under the supervision of the New York State Department of Mental Hygiene. It differs from most state institutions, however, in that it is especially designed for teaching and research purposes and admits its patients selectively. Located in physical promimity to the Columbia Presbyterian Medical Center, it has strong affiliative ties with various units within that complex.

This 182-bed facility is divided into six clinical services: the 10-bed Acute Service is devoted to the care of the acutely disturbed psychotic patient; the Drug Research Unit offers treatment to approximately 28 acutely depressed and suicidal patients; the Community Care Service has underway a pilot project for evaluation of the mental health needs of the community as well as providing inpatient facilities for 55 patients, a day care program, and a halfway house; the General Care Service provides treatment for about 65 adolescents and young adults; the Pediatric Service has a capacity of 16 and is designed for diagnosis and treatment of disturbed youngsters; the Metabolic Research Unit at present provides facilities for the study and treatment of eight manic depressive patients.

The Institute provides individual and group psychotherapy for its patients as well as a varied program utilizing the skills of occupational, recreational, and physical therapists. As patients progress, they are actively encouraged to take part in activities outside the hospital. Some regularly attend school or carry on full-time employment, returning to the hospital for the night and participating in evening activities and therapy.

Patients on the Children's Unit generally range in age from seven to fourteen. These children participate in a part- or full-time educational program within the hospital according to their individual needs. The staff actively involves the children in group planning and activities. Frequently small groups of children make visits to local recreational facilities or shopping areas. Each child receives an allowance appropriate to his age. Plans for family visits to the hospital and children's visits to their homes are made according to the needs in the individual situation.

## Follow-Up of Participants

In the original project proposal it was indicated that each workshop participant would be visited by the project director for a day at the end of the year following the workshop. The purpose of this visit was to try to determine, through observation of the nurse's work, what influences and changes might have been brought about by the workshop experiences. While on sabbatical leave, the project director visited three nurses in schools in western states with this purpose in mind. In each instance, contact was made with the principal of the school and, in one case, a lengthy discussion ensued. Since these three visits did not give evidence that personal contacts would necessarily yield more valid information than that which might be gathered by less expensive and time-consuming means, it was decided to alter the original plan. Consequently, follow-up was carried out by letter to the principals or supervisory personnel designated by the workshop participants. Participants were also asked to evaluate, at various points in time, the effects the workshop experiences might have had on their work. Summaries of both the participants' and their supervisors' evaluations are included in Chapter V.

## Reference

1. Milton J. Senn. Red Is the Color of Hurting. Washington, D. C.: United States Government Printing Office. Public Health Service Publication No. 1583, p. vii.

## Chapter II

## WORKSHOP PARTICIPANTS

The data regarding the participants were assembled from questionnaires plus government forms completed at the beginning of each workshop. (See Appendix, pp. 159-63 for a sample of the questionnaire used.)

### Geographic Distribution

Although no systematic sampling technique was employed for the selection of the workshop participants, nurses came from various geographic regions of the United States. Twenty-four states and the District of Columbia were represented. While the greatest number of participants came from the Middle Atlantic States, some came from more distant states including Alaska, California, and Texas (Table 1, p. 164).

### Age

The workshop participants ranged in age from twenty-six to sixty-one, with the median falling at about forty-five years (Table 2, p. 165).

### Marital Status

Approximately equal numbers of single and married women participated in the workshops (Table 3, p. 165). Among the total of 80 participants, 26 had one or more children (Table 4, p. 165).

### Educational Background

Because it was stipulated that each participant in the mental health workshops have at least a baccalaureate degree, all participants had this in common in regard to educational background, but they differed in other respects educationally (Table 5, p. 166). Sixty-three of the total of 80 participants, or 79 percent, had received their basic education in nursing in hospital schools of nursing. The remainder had graduated from generic baccalaureate nursing programs. While 71 had acquired baccalaureate degrees in nursing, nine held bachelors degrees in fields other than nursing, and one held a degree in another field as well as one in nursing. Of the group who held bachelors degrees in other fields, three held degrees in health education, four in general education, one in sociology, and one in psychology. Three in this group had subsequently acquired masters degrees in nursing.

Approximately one-fourth (N=19) of the nurses in the workshops held masters degrees in nursing. An additional 14 percent (N=11) had earned masters degrees in other fields including education, health education, health and physical education, educational administration, administration and supervision, and guidance and counseling. Several nurses indicated that they were interested in further education; two were engaged in doctoral study. Over half of the nurses in the workshops had participated in formal college study subsequent to their highest earned degrees.

Participants were asked specifically about their educational background in school nursing, psychiatric nursing, public health nursing and pediatric nursing (Table 6, p. 167). Sixty-six percent of the nurses (N=53) had had some formal education in the specific field of school nursing, about half of them having had one or more courses on an undergraduate level. Two participants had graduated from a generic baccalaureate nursing program with specialized study in this area, but most of them indicated that they had taken courses in school nursing while engaged in study toward a baccalaureate degree subsequent to their basic dimploma-school preparation in nursing. Of all the participants who had had preparation in school nursing on an undergraduate level, about half indicated that this preparation had included a supervised field experience.

Thirty-three student (41 percent) had had formal preparation in school nursing on a graduate level. Field experience in school nursing was included in only eight students' programs. Of the 34 percent of the nurses (N=26) who had not had formal preparation in the specific area of school nursing, many indicated that classes and field experience in public health courses had included some school nursing.

Most, but not all, of the workshop participants (86 percent, N=69) had had some formal education in psychiatric nursing, with the vast majority of these having taken undergraduate courses and only five having had graduate courses in this nursing specialty. On both undergraduate and graduate levels, however, some of the courses that had been taken by workshop participants did not include field experience.

Only one individual in the total of 80 workshop participants had not had some formal preparation in the area of public health nursing. Eighty percent (N=64) had had one or more undergraduate courses with field experience in public health nursing. An additional 14 percent (N=11) had had undergraduate courses in public health nursing but without field experience. Thirty percent (N=24) had had graduate courses in public health nursing, the majority of which, however, did not include field experience.

Relatively few workshop participants had had graduate education in pediatric nursing. Only five listed this as a part of their educational background. All of these five had taken courses which included field experience. Within this group, one individual had graduate preparation in child psychiatric nursing.

## Work Experience

One of the criteria used in the selection of nurses to participate in the workshop was a minimum of two years of experience in school nursing. With one exception* all participants met this criterion and the length of experience in school nursing ranged from two to 28 years (Table 7, p. 168). The average number of years experience for the total group was 11.

About half of the group had practiced school nursing at all educational levels, in elementary, junior and senior high schools (Table 8, p. 169). Ninety-one percent of the total group (N=73) had had experience at the elementary level; 76 percent (N=59) at the junior high school level; and 56 percent (N=45) at the senior high school level. In addition, three nurses had had experience in college health programs as well as experience in elementary and secondary schools.

Thirty-four percent of the workshop participants (N=27) had had work experience in both public and parochial schools (Table 9, p. 169). Sixty-three percent (N=50) had had experience only in public schools; 4 percent (N=3) had had experience only in parochial schools.

When asked to outline generally their past work experience other than in school nursing, the workshop participants presented a varied picture. Fifty-nine percent (N=47) had been employed as staff or head nurses in hospitals (Table 10, p. 170). Nineteen percent (N=15) had been supervisors or administrators in these institutions. About one-fifth of the group (19 percent, N=15) had at one time in their careers held positions in nursing education; most of these had been employed as instructors in hospital-sponsored schools of nursing; seven had served in the military nurse corps or reserves; and five had worked as private duty nurses. Various participants reported having been employed in other kinds of nursing practice from occupational health to missionary nursing.

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* The exception was a nurse who had had only one year of experience but who had recently completed a graduate program in school nursing including field experience.

Three had been in the field of general education, having been elementary or special education teachers at one time.

The workshop participants were asked specifically about their work experience in public health and psychiatric nursing. Fifty-six percent (N=45) of the nurses had had work experience in public health nursing, ranging from less than a year to 27 years (Table 11, p. 171). Of this group, most had worked from two to five years in generalized public health nursing prior to specialized work in school nursing. The majority of those with public health nursing experience had worked in official agencies (Table 12, p. 171). While most had worked as staff nurses, nine individuals had held the position of supervisor and three that of administrator (Table 13, p. 171).

Only three of the nurses in the mental health workshops had had more than minimal experience in psychiatric nursing (Table 14, p. 172). Of these three, two had had ten years experience and the third, two years. An additional ten people had had brief experience in psychiatric nursing, one year or less, but the overwhelming majority, 84 percent (N=67), had had none.

### Present Positions

At the time of their entrance into the workshops, about three-fourths (N=59) of the group held positions as staff school nurses although some variation existed in their titles (Table 15, p. 173). An additional 15 percent held supervisory positions in school nursing or, in one case, in public health nursing service. Five of the total of 80 held positions which carried the title of coordinator. In some instances,a nurse with a title of supervisor or coordinator also had responsibility for nursing service within one or more schools. Two nurses in the group were called consultants. One of these was employed by the maternal and child health division in a state department of health; the other held the title teacher-nurse consultant within a school. One nurse in the group of 80 was the director of public health nursing services within an official agency. One held the title of health counselor within a school.

The overwhelming majority of the nurses in the workshops, 91 percent (N=73), were employed by school districts rather than official public health agencies (Table 16, p. 174). Of the remaining seven individuals, six were employed by local official public health agencies and one worked for the State Board of Health. Several nurses reported that a local civil service board had the responsibility for filling positions in school nursing although actual supervision after a nurse was employed came from the school.

Administrative structures within which the nurses worked varied widely. The largest number of participants indicated that they worked in situations in which school health services constituted a separate department under a director who was responsible to the chief school administrator or his assistant. Twenty of the nurses stated that nursing services were included within the administrative area designated as "pupil personnel services" or "special services." In some instances, the head of this administrative unit served as a coordinator rather than a director with supervisory responsibilities. Three of the nurses indicated that the school health service was part of a department of health and physical education.

Some nurses working within each of the administrative structures mentioned above were in positions of dual responsibility of varying degrees. Often a nurse stated that she was responsible to her building principal as well as to a director of health services, coordinator of pupil personnel services, or chairman of health and physical education. However 18 nurses in the total group of 80 indicated that they had only one line of responsibility -- directly to the building principal.

Although the employment practices and the administrative agencies varied, the work of these staff school nurses in terms of functions and responsibilities seemed remarkably consistent. In general, they had responsibility for supervising or carrying out vision and hearing screening; assisting with physical appraisals; counseling students, parents, and school personnel on matters related to health; informal and, in some instances, formal health education; and developing policies and procedures related to prevention, promotion, and maintenance of health within the school. Most nurses shared regular faculty responsibilities and privileges with the rest of the school staff, attending meetings and serving on school committees. Most saw the promotion of school-community relations as a part of their work. Many mentioned that they worked closely with other special service personnel and teachers in assisting children who had physical, mental, or emotional problems and in modifying educational programs to meet pupils' individual health needs.

# Chapter III

## WORKSHOP I:

## CONDENSATION AND SUMMARY OF PROCEEDINGS

The first day of the first workshop began with a general orientation to the workshop, its originating idea, sponsorship, and planning. Some time was spent orienting participants to the Teachers College environment, particularly to the location and facilities of the bookstore and library. Their attention was directed toward the bibliography of reference materials that belonged to the workshop. The books on this list were placed on shelves in the classroom for the participants to borrow and refer to at will. Periodicals which frequently contain pertinent articles on children's emotional health were also listed, and participants were encouraged to share any other pertinent reading materials they might discover during the course of the workshop. A number of the registrants brought in or sent home for references they thought might be of general interest.

During the period of becoming acquainted through introductions, each participant was asked to briefly describe her work situation in respect to kind and level of school, number of pupils, and the administrative jurisdiction. The remainder of the morning was devoted to a beginning orientation to some of the theories that would provide a framework for future discussions.

## PART I

### Schools of Psychiatry

The schools of psychiatry from which the content of discussions was to be drawn was reviewed first with the workshop participants. Freudian psychiatry was described as in "inner" theory of psychiatry in that it is concerned with phenomena that occur within the personality of an individual. Sullivanian, or the American School of Psychiatry, was described as an "outer" theory, an interpersonal theory, which is concerned with the interaction of individuals with other people. Material was also to be drawn from such neo-Freudians as Robert J. Havighurst and Erik H. Erikson.

Five basic concepts or assumptions were identified:

1. Behavior is caused, and, therefore,
2. Behavior can be understood.
3. Behavior can be changed, hopefully in a positive direction toward health, satisfaction, and security.
4. There are multiple causes for behavior including, among others, those that are psychological and physiological in origin. The neo-Freudians, more than Freud, seem to have emphasized the interaction of physiology with psychology and to have considered the cross-cultural influences in mental health.
5. As needs are met, more mature needs arise. A corollary of this is that if needs are not met, the individual may regress to a less mature form of behavior.

## Concept of Mental Health

The concept of mental health was discussed with reference to the writings of Sullivan and Jahoda. It was stressed that mental health is a dynamic process; an individual is, hopefully, moving toward maturity with new needs developing as old needs are met. A mentally healthy person was described as one who is able to actively seek satisfaction as well as security. On the other hand, an individual who is mentally unhealthy finds it necessary to devote nearly all of his energy to maintaining security. Several examples of individuals needing more security were given:

1. A child who is so overly concerned with perfection in written assignments that he spends hours after school recopying his papers. This child seems unable to seek satisfaction because of his search for security in approval from his teacher and parents.
2. A child who asks for very specific directions. This child is frequently the first to ask "how many pages" when he is given an assignment by his teacher or to ask the nurse detailed questions about the care of a minor wound.
3. The school nurse who won't make home visits. Such an individual may feel secure only within her own health office.
4. The adult with the "weekend neurosis." He is able to function well during the work week but becomes anxious on weekends when he has "nothing to do"; he finds it difficult to enjoy himself.

When working with a child or adult who seems to be in any of these or like situations, the nurse may encourage him to express his concerns and feelings, help him to feel more at ease in the school environment, and aid him in discovering satisfying relationships and activities.

## Concept of Anxiety

The discussion then centered around the concept of anxiety. Anxiety arises in relation to need fulfillment and, according to Sullivan, anxiety is generated in interpersonal situations. A small amount of anxiety may be useful, as in motivating learning. After this minimal point, however, as anxiety increases, the ability to learn decreases. Sullivan states that mental illness has anxiety as its basis. When anxiety is decreased, movement of a person or group of persons toward health takes place.

Anxiety is felt in infants as generalized discomfort. This also holds true in adults in which anxiety may take the form of a vague feeling of being uncomfortable. (1) Anxiety is a communicable disease; the infant empathizes or "catches" it from his mother or from other people around him. In fact, anxiety is frequently communicated between people of all ages.

Anxiety and fear need to be differentiated. Fear has a specific object or focus: "I am afraid of ...." Anxiety is more generalized: "I'm scared" or "I'm uncomfortable." Therefore the latter state is the more difficult one with which to work as its source is less defined. Occasionally, generalized anxiety becomes "attached" to a specific object and is expressed as a phobia, an abnormal or irrational fear.

We learn to organize our lives to avoid pain; anxiety is painful. A threat to self-concept results in anxiety. Individuals have diverse ways of dealing with anxiety depending upon their physiology, culture, family patterns, and other factors. When one symptom of anxiety is removed, often another symptom may arise. It is important, therefore, to consider the cause rather than merely the symptom of anxiety.

Material derived from an article by Dorothea Hays was used as a basis for futher discussion of anxiety. (2) She differentiated four stages of anxiety: mild, moderate, and severe anxiety, and panic.

Mild anxiety is characterized by alertness. Noises may seem louder; the individual may exhibit restlessness or irritability; he may experience unexplained discomfort, uneasiness, or insomnia. Curiosity, repeated questioning, belittling of another individual, misunderstanding, and constant attention-seeking may be other signs of mild anxiety. Certain learning tasks may be identified for a mildly anxious person: he needs to recognize anxiety as a warning sign that things are not going as he had expected. Specifically, he may observe what is going on, describe what he has observed, analyze his expectations, identify differences between his expectations and his observations, formulate a means to change either the situation or modify his expectations, and validate his expectations and observations with others. An example of validation of observations with others can be seen in the instance of a "near-miss" accident situation when bystanders feel the need to talk over what has happened. The decrease of anxiety can be estimated by comparing the loudness of their voices at first with the gradually diminishing volume later.

Mild anxiety may be used, on occasion, to stimulate learning or activity. For example, the school nurse may use it when attempting to motivate a parent toward action regarding some health problem in a child. In some instances, the problem may be more troublesome to the nurse than to the parent because it is she, rather than the parent, who feels the need for action. In such a situation, she might try to arouse mild anxiety, offer support, and try to guide him into productive behavior.

Moderate anxiety generally results in increased tension and reduced ability to perceive and communicate. Such physiological changes as increased muscular tension and heart rate, perspiration, and gastric discomfort may be noticed. An individual may not hear someone talking or may not notice details in his environment. A person experiencing moderate anxiety needs to recognize that his focus is limited and that he may not see connections among details. If his tension can be reduced, he can then take the steps listed above to attempt to discover why the situation arouses anxiety for him.

An example of moderate anxiety occurring in nursing practice was described: A person receives instructions in regard to a health matter but doesn't really hear them. An instance specific to school nursing practice might be the child under stress who does not do well on a vision or hearing screening. In this situation, a thorough orientation to the procedure could greatly decrease tension and, at the same time, improve the validity of the screening.

In relation to moderate anxiety, the importance of the nurse's sensitivity to the emotional tone of a school was mentioned. Occasionally, the cause of moderate anxiety may be found within the curriculum, sometimes in interpersonal relations between the child and the teacher. The need of the child - or occasionally, the teacher - to "escape" from this kind of stress was discussed. The nurse can help in this situation by giving permission, verbally or by her behavior, for the individual to express his feelings. She can provide emotional support by creating the atmosphere for this expression and by actively encouraging it. Anxiety is reduced in the presence of an accepting person; in the case of a child, this person is most frequently an adult. Staying with the child and using touch may provide the necessary reassurance. Exploring the problem with him may be an aid in helping him to mobilize his resources to cope with the situation.

Severe anxiety is characterized by physical and emotional discomforts. Only details of the situation are perceived and connections among details are not recognized. Moderate or severe anxiety can be reduced by simple activities: walking, playing a simple game, or working at an uncomplicated, concrete task. Crying or talking to someone can also provide outlets. An individual experiencing severe anxiety is unable rather than unwilling to cooperate. In such situations, asking the person to make choices is contraindicated.

In the most intense stage of anxiety, panic, the individual may elaborate on a perceived detail which then assumes inordinate proportions. This person is usually unable to function and must have help in order to be comfortable. Panic carries with it the danger that the individual's personality will reorganize along different lines. Once panic has occurred, it is likely to recur. Nursing action here might consist of holding the child closely. Nonverbal methods are more successful in reducing panic than verbal.

During and following the presentation described in the foregoing paragraphs, discussion revolved around various topics. However, the topic most frequently brought up concerned anxiety and how to deal with it in its various forms, as indicated by the following partial list of subjects discussed:

Effect of anxiety on the nurse's communication

Anxiety on the part of both the nurse and the parent during home visits

Parental telephone calls to the nurse as an indication of their anxiety

Helping teachers to cope with their own and children's stress

General anxiety level of a school, i.e., the feeling tone, and the nurse's responsibility in shaping and maintaining it

The nurse's role in emotional first aid in various school situations and her concomitant responsibility for referral, when appropriate, to community mental health facilities

Working with children who use the excuse of illness to escape from an anxiety-provoking situation in the classroom; ways in which the nurse can identify these children and aid them and their teachers to modify the experience

Coping with withdrawal in cases of extreme anxiety

Other topics of discussion at this point included:

Interpersonal relations and cooperation with mental health personnel who are working with children and families and ways of establishing better relationships with community agencies

> The importance of looking for patterns of behavior rather than isolated incidents
>
> The variety of excuses that may be used to disguise a "cry for help"; the ways in which the nurse can recognize them
>
> Reality therapy and its emphasis on dealing with manifest problems as opposed to analytic therapies which emphasize the development of insight

The afternoon session of the first day was largely devoted to explanations and discussions of process recordings and the field experience the participants would have, including its nature and setting. Information about the field experience and the participants' reactions to it may be found in this chapter, pp. 51-78 ff.

## Growth and Development

The first session on growth and development began with an explanation that the terms psychological, personality, and emotional, as applied to development, would be used synonymously to describe the whole developmental process which continues throughout life from conception to death. Since it is now believed that the childhood determinants of personality are the foundation upon which the personality is built, the first years, especially the preschool years, are particularly important.

A summary of the developmental tasks and the evolvement of motor skills had been prepared ahead and included in the participants' individual folders so that they could be referred to as the lectures and discussions proceeded. Materials presented in both the dittoed summary and in the lecture sessions were derived from Ericson (3) and Sullivan. (4) The following paragraphs contain the gist of the lectures and discussions about growth and development.

As the developmental process begins, it is important to consider the family constellation into which the child is born: what his parents are like, their reasons for marrying, their ages, their cultural milieu, and the many other factors that influence the newborn. Of special significance are the attitudes of the parents toward the expected child during the pregnancy. Do they think of him as an object or a living being? Will his birth represent an interruption or inconvenience in their living patterns or an eagerly awaited event?

Superstitions and folklore have hinted at the prenatal influence of the mother's thoughts. To some extent there is truth in the idea that the mother's fantasies regarding her unborn child often influence her attitude toward him, thus having an effect on him after birth. Initial rejection of pregnancy occurs in approximately 85 percent of expectant mothers and, until quickening, there is little reality association for the mother between what is happening in her body and the arrival of a child. Rejection of the pregnancy during the first three months is normal; it is only when it continues throughout pregnancy that it becomes a cause for concern.

Because of the intrapsychic dynamics and the biological changes that occur during pregnancy, there is tremendous potential in the mother for maturation. The unconscious becomes more fluid and the mother may greatly profit from professional help during this period. At the same time, it is important to remember that psychic trauma, a death in the family, for example, or other emotional shock, takes its toll. The mother's psychic energy is largely involved in the pregnancy; there is little left over for coping with other emotional problems. Therefore, emotional depletion and, possibly, depression from such trauma often takes place later after the infant's birth, rather than at the time of the event. This point was illustrated in the film "Afraid of

School" (5) shown during the first workshop. A death in the family had occurred during the mother's eighth month of pregnancy, but her expression of grief took place primarily after the birth of the baby.

During pregnancy, the expectant mother usually has a greater need for dependency. She may depend more on her own mother, other relatives, or occasionally, her other children. The school nurse needs to be aware of this effect of a pregnancy on the other children in the family, for changes in their behavior in school may represent a reaction to these changes in the mother.

Basic attitudes and ideas about oneself arise from the early mother-child relationship. In a healthy relationship, the mother reacts to the child on the basis of her perception of the child as a person in his own right and attempts to satisfy his needs. She sees the child as an individual apart from her rather than as an extension of herself, and she recognizes that he may have a temperament different from her own. In a potentially pathogenic relationship, the mother reacts to the child in terms of her own needs rather than her perception of his needs. An example of this might be seen in a mother who rushes over to her child, picks him up, and hugs him, disregarding the fact that he is deeply absorbed in play. She is reacting to him in terms of her need for close physical contact at that moment rather than in terms of his need for learning through play activities. Occasionally, in a situation in which the father is not present, the mother's own loneliness and unmet needs usurp the child's energy.

There are both frustrating and satisfying elements in the healthy mother-child relationship. If a child's every need were satisfied, he might lack motivation to grow out of his present developmental stage.

From infancy to eighteen months, the major developmental task is the laying down of a sense of trust as opposed to mistrust. Freud refers to this stage as the oral period. Erikson, too, refers to orality. It is a period of very rapid physical as well as emotional growth. As the end of the first year approaches, the child's brain is two and one-half times larger than when he was born. During the first three months, the infant exists on the subcortical level. It is primarily a period of instinctual responses since ego formation and the conscious part of the personality develop concurrently with cortical development. The infant's responses, then, are limited. They include the showing of pleasure and displeasure. He has at this stage no capacity to delay need gratification. If his need is not immediately met by those caring for him, he shows his displeasure by crying.

During this early period, the mother's sensitivity to the infant's needs is very important. Sullivan refers to an empathic feeling between the mother and child, an unconscious relaying of messages. (6) A baby will often sense his mother's anxiety. A harassed mother and a harassed family often result in a colicky baby. On the other hand, the mother may be all too aware of how she is affecting her baby and be overwhelmed by the responsibility. She may need to be reminded that all babies must learn to cope with some frustration.

The mother sees a tremendous change as the baby becomes older. During the 3-months to 1-year period, the infant becomes a person. In the early part of this stage he begins smiling and responding socially to his mother. This has been called the "perfect baby stage." At about seven or eight months the infant becomes more independent. He shows more aggressive behavior by biting and grabbing. He is beginning to recognize his separateness from the mother and to establish his own self-identity and self-image. As Sullivan describes it, the baby explores his own body and the world around him and realizes that some things "don't feel back" and are therefore objects apart from himself. At this stage, one can learn a great deal about the mother-child relationship by observing the feeding situation, for disturbances in this relationship will often be manifested in feeding problems.

In contrast to the infant who has the benefit of a good mother-child relationship, the infant who does not receive mothering is often apathetic and depressed, as both Anna Freud (7) and Bowlby (8) brought out in reports of work with institutionalized infants. One factor in this syndrome is sensory deprivation in which the infant lacks the stimulation necessary for growth. Another is the lack of ongoing relationship with one adult, the mother or mother surrogate. Each of these situations may occur occasionally in the home as well as the institution. If the parents are unable to care adequately for the child, perhaps a relative or neighbor can serve as surrogate to avoid the effects of maternal deprivation.

At about eight months of age the infant goes through a period in which he is fearful of strangers and cries when his mother leaves him. This anxiety is related to his concern about separation from his mother. At this point in his development, he has learned to distinguish his mother from other people and has developed memory, but he has as yet little concept of time. When his mother leaves he has no idea of how long she will be away or if she will return at all. Gradually, he becomes reassured as he discovers that she does return.

From eighteen months to three years. Sullivan calls the years between eighteen months and six years the childhood period and states that childhood extends from the appearance of speech to the appearance of the need for playmates. (9) Often childhood is divided into two stages: the toddler stage (age eighteen months to three years) and the preschool period (age three to six years). Throughout the entire period, we see the beginning of individuation in which the child starts to separate from his mother and to delay satisfaction. The later years of this stage are particularly important in the child's development of sexual identification. Erikson describes the toddler stage as one in which the major task is the development of autonomy versus shame and doubt. During the preschool stage, the focus is upon the task of developing a sense of initiative rather than guilt. (10)

During the second year, the child develops in mastery of his physical world and of himself. As he begins to resolve the symbiotic relationship between himself and his mother, he moves toward independence. Hopefully, the mother gives the child opportunities to learn independence, yet understands when he retreats to dependence. Power struggles sometimes develop during this stage, particularly around the issue of toilet training. The mother needs to realize that sphincter control for bowel training doesn't develop until eighteen to twenty months of age and that bladder control is an even more complex skill that may not develop until the age of two years in girls and perhaps three years in boys. Throughout this period it must be remembered that feeling tone is most important. If what is done in the way of training or discipline is done with genuine feeling of affection, the results are more likely to be positive than negative.

During the second year there is also a tremendous growth in the child's ability to communicate. Language development begins earlier with babbling but, by the second year, the child has achieved the important "ma-ma" and "da-da." He has also begun to communicate negative reactions and perhaps it is from this that the label "the terrible twos" arises. During this second year, it is important for the parent to distinguish for himself the "necessary no's" from the "convenient no's" so that he does not surround the child with forbidden objects or activities. An illustration was given of the "well disciplined" child: the child is beginning to cross a street but does not notice a car coming toward him. His mother, some distance away, sees the situation, cries to him "Stop!" and he stops. This child has learned that some things are forbidden because they are dangerous. He has not been so surrounded by "no's" that he has come to disregard warnings.

It is at this stage that sleep problems may arise. Frequently, one sees this problem in the child whose mother works and is away from home during the day. In such a situation, the mother has ambivalent feelings about putting the child to bed. She hasn't seen much of him that day and, although she knows he ought to be asleep, she would like to keep him up to spend more time with him. At this stage, the child may have fears about going to sleep, and nightmares are common. The child may develop rituals as normal protective devices to enhance security. Many of these various sleep problems are manifestations of the child's awareness of his separation from his mother.

The preschool period, age three to six years, is described by Sullivan as a period of learning to accept interference with one's wishes with relative comfort. The child of this age becomes increasingly able to tolerate frustration. A 3-year-old, for example, is learning to postpone immediate gratification.

The preschool period is an age of fantasy. Selma Fraiberg describes this beautifully in her book The Magic Years. (11) The 3-year-old is experimenting with language, too, often in the form of "silly talk." He is now able to identify himself by name. During this period the child is developing the rudiments of abstract thinking but he is not yet able to decipher meaning from symbols. This necessary maturation for learning to read comes later, at age four or five.

Expression of aggression becomes more "civilized" throughout the child's development. At this age, however, temper tantrums are not unusual. Often aggression in the 4- or 5-year old is indicated by "bossiness" which represents an attempt to control his environment. The manifestation of aggression is culturally determined to a large extent; for example, boys seem to be expected and permitted to act out aggression more than girls. During the early part of this stage, parallel play is most common. If the parents wish the child to attend nursery school, a school organization which ensures small groups and one constant teacher would be advisable.

Sibling rivalry is normal at all ages but its manifestations may be more obvious in the preschool child. Each child who is displaced by an immediate successor on his mother's lap feels a natural ambivalence toward the sibling. Often a temporary regression occurs accompanied by bids for attention on the part of the displaced child.

Sexual curiosity and exploration is also normal at this age. It is not, however, the adult form of sexuality. Often parents find it difficult to reach a balance between a restrictive and a permissive attitude. Some seek to assume a very permissive attitude although they themselves are not entirely comfortable with it. Congruence between parents' real attitude and behavior is important. They must consider, too, what society in general expects in regard to behavior or conversation related to sexual matters. The child needs honest answers to his questions but premature or overly complex explanations can be confusing to him.

In Freudian theory, the preschool stage is the oedipal period in the child's development. This stage seems to be more pronounced in our culture than in others, perhaps because of our emphasis upon sex role differences. During this period, the child develops a "crush" on the parent of the opposite sex. Occasionally this results in difficulty within the family if one parent seizes the opportunity to play the child against the other. Throughout the oedipal period the child may need to be reassured of the love of "his competitor," the parent of the same sex. This parent becomes his role model in the development of sexual identity.

The juvenile period, age six to nine years, is defined by Sullivan as a time when the developmental task is learning to form satisfying relationships with compeers. (12) The child's family is still very influential in his life but not quite as predominant as his attention moves toward making friends with age mates. Erikson sees this period as one in which the child develops a sense of industry. (13) He has also developed the ability to deal with abstract concepts, i.e. he can think symbolically, so simple mathematic and language study can logically be introduced. By now the mechanism of repression has been well developed. The child is "civilized" in that he has learned the mechanisms of inhibition and denial.

The child of this age is constantly active, the activity being perhaps a sublimation of tension. This is the period of curiosity, of clubs, of secret languages, of competitive group games. Such rivalry with age mates represents the constructive channeling of the aggressive drive.

Vacillation between being grown-up and being childlike is not uncommon at this age. Separation from home may be difficult for both child and parent. The school may be influential in making this separation easier for both. In school phobia the child may change his fear of separation into a fear of the teacher and the school. This fear constitutes a symptom of an underlying problem, one which concerns the mother-child relationship rather than the child alone. Again, the film "Afraid of School" helped the workshop participants to understand this problem.

Slightly compulsive behavior is common between the ages seven and nine. The child has assimilated codes of behavior from his parents and is testing them by use. The "rules of the game" are important to him and "playing fair" an essential element of approved social behavior in the group. Resistance to change in plans or established procedures is common. The child of this age also has relatively well organized concepts of time and space. He tends to develop his own special interest during this period and frequently becomes an avid collector or hobbyist. An enthusiastic interest in television is not uncommon.

Preadolescence, age nine to twelve years, is a period during which the emphasis moves toward establishment of a relationship with one particular individual, a chum of the same sex. This is the "best friend" stage. A temporary regression is not uncommon. Restlessness and tension may indicate physiological changes which herald the approach of adolescence. Tics, learning difficulties, psychosomatic illnesses, hypochondriasis, and other neurotic tendencies may reveal themselves. Fritz Redl, in writing about this age, suggests that parents avoid reacting to surface behavior of their child, avoid fighting the child's histrionics with counter-hysterics, and avoid over-reacting. (14) Parents should also avoid the temptation to revert to old forms of punishment, the kind they may have used when the child was a preschooler. An appeal to his morals and good sense is more likely to be successful.

Preadolescence is a good time to capitalize on the child's restlessness and encourage him to experiment with new experiences, to try out new things. Summer camp, for example, might be initiated to give him experience in group living away from home. Teachers may capitalize on the need for experimentation by utilizing a variety of teaching techniques and by introducing new methods. Role playing may be particularly effective at this age.

Adolescence is frequently spoken of as consisting of two periods - early adolescence and late adolescence. Early adolescence extends from the first evidence of puberty, usually between the ages of twelve and fourteen, to the completion of physiological maturation. Sullivan defines the developmental tasks for this period as learning to become independent; to evaluate one's own limitations and powers; to critically evaluate ideas, beliefs, attitudes and values; and to establish relationships with members of the opposite sex. (15) Later adolescence, approximately ages sixteen to twenty-one, begins with the completion of physiological maturation and ends with the establishment of a durable situation of intimacy and the choice of a love object of the opposite sex. The tasks are similar to those of early adolescence: continuing development of independence and identity of oneself as a complete human being. Decisions of far-reaching consequence, career choice for one, will be based upon what he believes to be his interests, aptitudes, and abilities. The growth of early adolescence continues during this period as the individual forms more durable relationships with members of the opposite sex. At this stage and in this relationship, he learns how to be interdependent with another person.

Erikson speaks of this stage of adolescence as a time that is characterized by the establishment of identity versus role confusion. (16) In establishing a firm sense of self, the adolescent may need to try out new roles. Yet he also has a need to identify with his peers and to conform to their standards of behavior. Josselyn describes the adolescent personality as "spongy," that is, very fluid, absorbing, and unpredictable. (17) This accounts for the moodiness so characteristic of adolescents. Falling in love in early adolescence is usually a growing awareness of one's own feelings of affection and tenderness rather than direction of these feelings toward a specific person. In later adolescence it more often represents a feeling toward another individual along with awareness of one's own unique individuality. Adolescents also have to deal with their developing sexual feelings and cope with confusion, fear, and tension arising from this new experience.

Anna Freud comments about how little we know of the psychoanalysis of adolescents and how little we can reconstruct about this period of personality disorganization from adult analyses. (18) The adolescent experience seems to be cross-cultural. In other cultures, adolescents may begin to assume the adult roles of marriage and family responsibility earlier than is generally permitted in our society.

Adolescence has been described as an almost schizophrenic process. Some of the symptoms associated with schizophrenia are present, ambivalence and a sense of strangeness or unfamiliarity with oneself, for example. The latter, however, may be attributed in part to the actual bodily changes that are now taking place at an accelerated pace.

As mentioned previously, mood changes seem to be characteristic of adolescence. They may be symptomatic of anxiety, fear of adult responsibility, or an ambivalence about independence. Girls, perhaps, have a more dramatic puberty in so far as menarche is an identifiable event that draws attention to the many more subtle physical and emotional changes which have been taking place. Menarche may symbolize to a girl her entry into womanhood with whatever implications that event may carry for her individually. It may be accompanied by fantasies, fears, and anxieties as well as anticipation of adult privileges and responsibilities. Occasionally menarche has a subconscious association with injury.

Hypochondriacal symptoms are not uncommon. Physical exhaustion sometimes stems from the effort of dealing with all these new feelings as well as the rapid physical growth. A fondness for candy and other sweets may represent a return to immediate oral gratification to allay anxiety. This period is also a time of reactivation of earlier conflicts of the pre-oedipal period.

The adolescent's family shares this difficult period with him. It is often a time of stress for them as well, particularly if the parents themselves had a difficult adolescence. Old conflicts may be revived as they see their son or daughter coping with similar problems.

## Communication

On the afternoon of the third day of the workshop, attention was focused on communication. Communication was defined as all procedures or processes that people use to influence the feelings, attitudes, and knowledge of other people. It is a dynamic process. It is basic to education and to socialization, and serves as the main tool in interpersonal relations. Since nursing is a helping relationship, communication is basic to effective functioning.

A basic mental health concept is that an individual must be able to relate or to communicate with at least one other person. Otherwise he lives a lonely, isolated life. Some psychiatrists take the position that mental illness is a disturbance in communication. Jergen Ruesch is one who adheres to this view. Students were referred to one of his books, Nonverbal Communication, which was among those available in the workshop library. (19) Regardless of the schools of psychiatry they represent, most psychiatrists agree that one of the goals in treatment is to help the individual develop ability to communicate with at least one other person, to share his feelings and experiences. Any event that interferes with communication to a severe degree will produce an emotional disturbance. Recent research in sensory deprivation supports this hypothesis. Research subjects often develop symptoms of emotional disturbance under conditions of extreme isolation. Studies of young infants who lack sufficient stimulation show that they also develop such symptoms.

Communication is universal. It includes all meaningful social interaction. There are three basic modes of communication: 1) nonverbal, which includes art, music, dance, body posture, and the like; 2) para-verbal, which includes tone of voice, rate of speech, etc.; and 3) verbal. Nonverbal communication is the first mode of communication one learns. The empathy between the mother and the infant seems to involve something beyond physical touch; the mother conveys her feeling as well. Some believe that one must learn how to use nonverbal communication in order to grow normally. Since it is the most primitive and basic way of communicating, we reveal more of ourselves in nonverbal communication than we do in either of the other two types. Some of David Levy's work in observation of maternal behavior has implication for nursing; he has noted, for example, how the mother holds the baby and how often she looks at him. (20) Verbal communication is the most civilized and most complex since it involves symbolization. Symbols may have both a dictionary meaning and an emotional meaning, i.e. a denotation and a connotation.

Five factors are involved in effective communication. First,there is the communicator who initiates the message; secondly, the communicant who receives the message; thirdly, the communique, the content or message; and fourthly, cues as to the effect of the message. Cues may be described as feedback or response to the communication. The communicator makes observations to test the success of the communication, to see if the message was received. Feedback is important to the continuation of the communicative process. It is influenced by the communicator's perception and the willingness of the communicant to respond. The fifth factor is the context or the physical, social, and emotional environment in which the communication takes place. The environment has a definite influence upon the success of the communication. For example: the physical environment of a warm room may cause a decrease or breakdown in communication; the social atmosphere of a party influences the process of communication; and the emotional stress of a situation in which one feels uncomfortable may limit the effectiveness of communication. One basic principle, then, is that a trusting environment is essential for meaningful communication. The individual must feel that he can express his attitudes, thoughts, and feelings. Occasionally he may receive conflicting messages between the verbal and nonverbal communication; the verbal message may be "open up"; the nonverbal, "keep quiet."

We need various kinds of knowledge in order to foster communication. First we must have an understanding of human behavior. It is of particular importance that we have an understanding of the influence of anxiety on human behavior, how it is manifested, and how it affects people's functioning. Secondly, an understanding of the principles of perception is important. Perception is the process by which meaning is given to what one sees or experiences. We need to know that each individual perceives things differently from other individuals and that anxiety distorts or reduces perception. With knowledge of these principles we may become aware of our own reactions; we may study what we do, why one course of action is more successful than another. We may look at ourselves as one who is interacting with another. We may also develop better ways of communicating with others. For example, we might learn to communicate more concisely and directly, or perhaps use other than verbal modes of communication when interacting with an anxious individual.

Awareness of one's own reactions is of particular importance in communication. We must, in fact, study our reactions, for we react selectively rather than equally to all stimuli in the field. We work with people's perceptions; therefore, we need to understand how things appear to them. They behave according to what they see and feel, not according to what we see and feel. There is a constant need for checking and correcting our perceptions to attempt to ascertain if the person really feels how we think he feels, or if our assumption about his feelings is a projection of our own feelings.

Paul C. Buchanan, in The Leader and Individual Motivation, lists five principles that are particularly important in exploring why people behave as they do:

1. The way a person behaves depends on both the person and his environment.
2. Each individual behaves in ways which make sense to him.
3. An individual's perception of a situation influences his behavior in the situation.

4. An individual's view of himself influences what he does.
5. An individual's behavior is influenced by his needs, which vary from person to person and from time to time.

He says that all behavior reflects the operation of these five forces. (21)

In the discussion of Buchanan's first principle, it was emphasized that it is "fit" or interaction between the person and his environment that is crucial. An example was derived from the situation of a child who misbehaves in one school and, after transfer to another, seems to adjust well. In regard to the second principle, if an individual's perceptions of a situation do not seem to make sense to him, he attempts to make them reasonable. Discussion of the third principle emphasized the responsibility of the professional person to feed in information to correct misperception.

Many factors influence perception: age and understanding level; physical factors such as current state of health past experience and personality factors, for example, unfavorable past experience might cause a person to lack trust and perceive the world as hostile; interests and needs, for example, the perception of food is influenced by present state of hunger; desires; fears; values and culture; and general attitudes and expectations. Feedback is particularly important in correcting or validating perception.

Buchanan states further that what a person does is a consequence of both the person and his environment:

> His behavior can be determined (1) almost completely by his own skills, attitudes, and capabilities; (2) almost completely by some aspect of the situation; or, as is usually the case, (3) by some combination of both.
>
> Thus, if we want to understand and work effectively with others, we should give attention to the individual and to the situation he is in and to the relation between him and the situation. Some situations tend to activate people in a certain way - to make them

> bored, irresponsible, uncreative, to direct their ingenuity in ways that do not contribute to the objective intended by the leader, etc. Other situations bring about a very different response - enthusiasm, responsibility, and creativity - from the same person or the same group! The leader should also expect different individuals to respond differently to what appears to the leader to be the same situation. (22)

Several other points must be kept in mind. First, we are selectively inattentive, either consciously or unconsciously. Secondly, feelings are expressed in both words and bodily movement. We must listen for the meaning behind the words and watch for actions that may give the clue. Sometimes, as mentioned previously, conflicting messages are sent via words and actions. Some theorize that the origins of schizophrenia lie in the situation in which a young child is continually subjected to these double messages from parents.

Measures to improve communication skills were outlined. First, acquiring intellectual mastery of certain understandings such as human behavior and the concept of anxiety; second, practicing interviewing and counseling techniques; third, gaining insight into one's self; and fourth, developing increased ability to perceive, to utilize all one's senses, and to be more aware of every sense.

In relation to the latter two, sensitivity training was discussed briefly. The goal in such training was described as increasing one's insight into one's self and one's way of interacting with other people. It consists of exercises to increase awareness, particularly self-awareness, and an intense group experience. Often it entails physical isolation of the group for a period of time, a weekend, for example. Sometimes dyads are formed to increase self understanding through intense interaction with one other person. In this situation, each person serves as a mirror for the other, providing feedback regarding his perceptions of and reactions to his partner. This concept of a "mirror relationship" with someone can be most useful outside of the sensitivity training situation. For additional reading on sensitivity training, participants were referred to Joy: Expanding Human Awareness, by William Schutz. (23) Finally, the relationship between communication and motivation were discussed. Communication is a means of motivating another person. A pamphlet, Motivation and Human Relations, written by Lester Tarnopol and published by the American Society for Training and Development, is a useful reference in this area. It deals with frustration, discipline, perception, interviewing techniques, and basic human needs. It would be useful in a variety of work situations and particularly in inservice education programs.

### Discussions With the Psychiatrist

Toward the end of the first week, a psychiatrist who specializes in work with children joined the workshop staff. In all, he spent four 2-hour sessions with the group during which many topics were discussed. Some of the topics arose from the participants' field experience in the hospital; some from situations they had encountered in their school nursing practice. Since a full report of all topics explored would be impossible, ten samples that are illustrative of the topics most frequently mentioned are given in the following paragraphs.

The child who becomes hospitalized. Participants stated that they had observed many different techniques of adjustment to hospitalization among their assigned patients. The psychiatrist was asked to explore this topic and explain the psychodynamics underlying various modes of behavior. For example, one reaction to hospitalization was manifested by a child who took on the responsibility of caring for or "looking out for" other children. The behavior was explained as the conversion of anxiety into more constructive action, the assumption of the role of caring rather than the role of patient. Preparing a child for hospitalization was discussed. The importance of decreasing the fear of the unknown and of encouraging the child to express his apprehensions about the matter were stressed.

The child and death. In their field work, several of the participants were assigned to hospitalized children who were faced with a serious surgical condition or a terminal illness. They were concerned about helping the child cope with his fear of death and were seeking ways of encouraging him to express his feelings. Other students had encountered situations in their school nursing practice when a member of a child's family, a fellow pupil, or a pet has died. During discussion, the psychiatrist suggested ways in which the nurse might help the child express his thoughts, fears, and feelings about death. He pointed out that sometimes it is better to explore the subject further, to discover why the child is asking the question, to encourage further ventilation rather than to give a direct answer to a child's question (see also pp. 117-120).

How to tell when a child needs help. The evaluation of children in order to identify those who are in need of professional mental health services within the school or community was a topic frequently discussed. The psychiatrist listed three areas in which the child might be evaluated through answers to the following questions:

1) How is he achieving in school?
2) How is he relating to his peer group?
3) What is his happiness-unhappiness ratio?

Answers to these questions, he felt, would be good indicators of the presence or absence of difficulty. Few symptoms are well defined in most situations in which a child may need help.

The child and sex. Participants asked many questions related to their role in helping the child understand his own developing sexuality. Some recounted situations in which they had been asked to assume a major responsibility for this aspect of the school's health education program, or in which individual students had sought their advice. The psychiatrist emphasized the importance of an open and honest approach in the giving of information. He outlined the stages of sexual development and the common fantasies of the child at each age.

Discussion also arose about how the nurse might react in those situations which involve sexual behavior usually considered unacceptable in our society. The psychiatrist saw the nurse's role as a helping one - helping the student to clarify the alternative modes of behavior, to consider the advantages and disadvantages of each, and to make his decision about his behavior on the basis of a thorough exploration of the subject and his feelings about it. She can also help by providing an accepting atmosphere in which the child can express his concerns and ask questions. The nurse must be aware of her own feelings concerning the entire subject of sexuality and sexual behavior and avoid projecting her reactions onto others.

The psychiatrist discussed the problems of the unwed teenage mother, the possible meaning of the baby to her, and the conflict that may arise from decisions she makes regarding the infant's future. More than a few of the workshop participants had had experience in working with girls in this situation and their families. The psychiatrist also drew attention to problems of the teenage father who must cope with feelings of guilt and responsibility for the mother and infant.

Hypochondriasis in children. Participants asked how nurses can differentiate hypochondriasis in school children from malingering. Hypochondriasis was defined as a condition in which there is actually a symptom present, but in the child's thinking or worrying about that symptom, its significance and consequences are exaggerated. The psychiatrist associated hypochondriasis with low self-esteem. Thus, work with a hypochondriac must be geared to building up the student's self-esteem rather than merely reassuring him about his health. Hypochondriasis seems also to be associated more with the adolescent period of growth than other stages.

School programs for exceptional children. Some of the workshop participants had had experience with various kinds of programs for exceptional children. The pros and cons of centralizing all special classes in one school versus decentralizing the classes was discussed. Under decentralization, a special class is placed in a regular school and pupils from both special and regular classes may join in some activities. The success of this plan, however, depends largely upon the attitudes of the school administrators, teachers, and other pupils. If they are accepting, pupils in all classes can profit from learning to work with one another. On the other hand, sometimes the special class becomes isolated within the regular school. Centralization of special classes has the advantage of having clinical team services more readily available.

### Large group discussions

During several sessions in the second week, the entire group of workshop participants met with the teaching staff to discuss the application of what they had learned about mental health, and growth and development, to their work in school health. Again, a summary of all these sessions would be impossible. The following three samples are illustrative of the topics covered in them.

Education for family life. Many participants had been involved in the planning and implementation of programs of sex education, or education for family life. Workshop participants seemed to agree that the school has some responsibility in this area but one of their major concerns was the extent to which moral values and attitudes are or should be a part of this education. Some participants argued that education in general is more than a mere imparting of information, that in essence it involves change in attitudes and behavior. Education for family living should be no different. Others raised the question of pupils' preexisting attitudes and values and those of their families. Has the school the right to attempt to change these attitudes and if so, whose attitudes will it adopt as standard? The participants generally agreed that involvement of both the school and the family in decision making for family life education is desirable. The emphasis might be examination of various attitudes including one's own in the light of knowledge of the outcomes of behavior for both the individual and society.

New child in school. In regard to the situation in which a child has to transfer into another school, the two chief questions were: "How can the child be made to feel comfortable in the new environment?" and "How can the school best obtain the important information it needs about the child?" Various plans for orientation of a new pupil were discussed. Introductions to various school personnel and involvement of other pupils in orienting a new pupil were described as current practice in many schools. Often a conversation with the nurse is included in this first day's activities. Conferences with the new pupil and his parents were listed as being most helpful in introducing the school to the child and vice versa. Having his parents fill in various questionnaires or a health history inventory is also useful in gathering pertinent background information about the child. All of the discussants agreed that a warm friendly atmosphere set the stage for making the child feel at ease and for initiating a mutually cooperative relationship between the school and the child's home.

Volunteers in the school. In the effort to involve communities in their schools as well as to relieve the schools' professional personnel of time-consuming non-professional tasks, many schools have been experimenting with volunteer programs. Several workshop participants related their experiences with volunteers working in the health office. Reactions were both positive and negative and during the discussion several problem areas were identified: 1) defining appropriate tasks for volunteers; 2) orientation to the school and specific task; 3) coordination and scheduling; and 4) maintenance of confidentiality of health information. It was suggested that attention must be given to each of these concerns when planning a volunteer program.

Educational Films

Four films were found to be most helpful in presenting material in the first workshop. "The Task of the Listener" (25) aided in presenting some major concepts about communication. This 30-minute film is narrated by Dr. S.I.Hayakawa, who addresses himself to the major question: "Why is it that some communications are welcomed and acted upon gladly and others are ignored or rejected?" He answers this question in terms of personality theory. Drawing on the writings of Carl Rogers, Donald Snygg, and Arthur Combs, he explains that a major aim of the human organism is to preserve, maintain, and protect the self-concept. If a message from one individual serves to threaten the self-concept of the person to whom the message is addressed, the communicant rigidifies his self-concept in defense and, in turn, frequently sends back a verbal or nonverbal message which threatens the original communicator. Eventually, a communicative deadlock occurs which can be broken only by what Rogers calls non-evaluative listening. Dr. Hayakawa's point of emphasis is that unless we listen as well as speak, no communication is possible.

"Bold New Approach" (26) is a film designed to illustrate the community mental health concept. It focuses around the needs of one community as plans are made for a proposed mental health center. Brief dramatic sequences illustrate the kinds of mental health problems that various people in the community have and the type of treatment facility which would be most appropriate for each. In planning the community mental health center, the utilization and coordination of existing facilities is considered as well as the addition of new services. Throughout the film, the emphasis is upon providing the amount and kind of help which is appropriate for each individual in a manner that will be most in accord with his normal life style of family relationships and occupational responsibilities.

"The Enemy In Myself" (27) consists of filmed family interviews with a psychiatrist. In this sequence, a family seeks help from a clinic when one of their 9-year-old twin boys leaves a suicide note. In subsequent sessions over a period of time, family relationships are explored and some of the hidden fears and emotions revealed. Of particular interest is the "scapegoating" which has taken place within the family as the aggression and hostility within various family members find expression in the behavior of one of the children. Throughout the film, the emphasis is upon the problem of the family rather than that of the child and the psychiatrist demonstrates how a solution may be reached through family therapy rather than individual psychotherapy.

"Afraid of School" (28) is a 28-minute film which tells the story of Tommy, a 6-year-old who refuses to go to school. Through play therapy and a psychiatrist's interviews with Tommy's parents, some of the factors contributing to his behavior come to light and the family is helped to find a solution to their difficulty. This film raised two topics of discussion. First, school phobia as a symptom of a separation problem that involves both child and parents and, secondly, the impact of a death in the family. Nurses identified and discussed what they saw as significant aspects of the situation. Among those aspects mentioned were the mother's ambivalent feelings about separation from Tommy, emotional detachment of the father, Tommy's manipulatory behavior, his fears of separations which were associated with fears of death, and the psychiatrist's method of interviewing which aided the parents in developing insight into their own behavior. Since part of the child's problem seemed to stem from his mother's difficulty in dealing with the death of a daughter which occurred while she was pregnant with Tommy,the discussion led to consideration of the impact of this on both the mother and child. Several points were made in relation to the mother's reaction to the death of her daughter. First, dealing with grief during pregnancy can be particularly difficult since much of the mother's psychic energy is involved in the pregnancy itself. Reaction to a tragedy, then, may be delayed until after the birth of the infant. Secondly, this mother's grief and depression altered her behavior toward the infant. She attempted to hide her grief from her other children but allowed herself to express it while tending the infant, believing he would not be affected. Suggestions were made about what a nurse might do in such a situation: 1) encourage the mother to work through her grief at the time of the child's death; 2) aid her in verbalizing her feelings of grief and perhaps guilt associated with the event; and 3) help her to understand that her infant is affected by her emotions and behavior. Discussion also revolved around how the death of a family member affects a child. Since this topic was also one which students raised with the psychiatrist, in both the first and second workshops, summaries of these discussions may be found in Chapter IV, pp. 117-20 ff.

## PART II

### Field Experience

The field experience of the participants in the first workshop consisted of visits with a hospitalized child each day for seven consecutive days. During these visits, each of which was 45 minutes or an hour in duration, they were to converse with the child, play with him, and observe his behavior, and their own, during the interaction. The objective was to assist each participant to increase her sensitivity to children's verbal and nonverbal behavior and her awareness of her own reactions and patterns of behavior with children. Each participant was asked to keep a process recording of the interaction (see Appendix, p. 198, for sample process recording form). A review sheet for the process recordings was provided to aid the students in analyzing their work (see Appendix, p. 199, for a sample review sheet for process recordings). It attempted to identify significant aspects of the interaction which the nurse might examine.

Children to whom the participants were assigned were selected with the aid of the nursing staff on the unit. (For a description of the cooperating agency, Babies Hospital, see Chapter I, pp. 6-7). The children were all of school age and an attempt was made to select those who were expected to remain in the hospital for the entire length of time of the field experience. On some occasions, it was not possible for a participant to sustain contact with only one child for the entire period, for example, when the child's discharge from the hospital intervened. In such instances, the participant was assigned to another child.

Prior to the first visit, the field experience was discussed and orientation to what was expected of the participants was given. They were to assume the role of "visitor" to a child and wear the pink smocks of the regular hospital volunteers. Time was deliberately planned within the workshop schedule for exploration of the students' feelings in regard to the field experience. In spite of a lengthy discussion on the day prior to the start of the field experience, a number of participants were uneasy about this part of the workshop. Some were concerned about returning to a hospital environment and working with children who were ill or perhaps in pain. Others felt ambivalent about the role of "visitor," or uncomfortable with the new role in which the expectations, limits, and purpose were somewhat nebulous. On the other hand, some had a sense of relief that they would not be expected to function as a nurse in this unfamiliar situation. A third major concern was that of acceptance by the child. "What if he doesn't like me?" was a question which at least one in each group raised. Finally, the participants had to cope with meeting the teaching staff's expectations in regard to the written process recordings and analysis of the interaction. Looking critically at oneself, one's feelings, and behavior proved to be an anxiety-provoking task.

Participants were asked to include in their process recordings a brief description of some of their feelings and impressions about this first visit. One nurse wrote:

> If there had been a choice of visiting a child or doing something else I would have chosen the alternative. I didn't want to do this visiting. There are conflicting emotions about this -- mainly because I'm not sure how to go about it or what really is expected of me or how I will be received. On the other hand, one of the things I lack in the association with children is communication and understanding of how to go about it. However, going into the hospital doesn't bother me - the fact that I'm not really part of what is going on is the disturbing factor. Will I be able to "mind my own business"? Will I be able to talk with the child and analyze the relationship?

Another participant summarized her reactions in this way:

> I approached this visitation with varying emotions:
>
> 1. Lack of understanding - Did we have to analyze everything we or the child said and did?
>
> 2. Uneasiness - Will this child accept me? Will I be able to establish rapport? I guess, basically - will the child like me?
>
> 3. Curiosity - What will the child be like? Will it be easy for me to carry on a conversation? Will I be able to last an hour? Am I good enough to observe and report accurately?
>
> As I re-read the above, I have to admit my feelings were more negative than positive, and I was concerned mainly with my own needs. Would I present a good picture? Would I make a good accounting of myself?

Hesitantly at first, and then with increasing confidence, the nurses established relationships with their assigned children. They tried to listen more carefully, to consider what they said in response to the child, and to observe nonverbal behavior. Later each day they were given time to attempt to reconstruct what happened and to set it down in a process recording. An example will best illustrate the trials and rewards the participants found in their field experience.

First day:

> It's certainly going to be different approaching a child with nothing to offer him but friendship. Always in the past I've had something he needed or wanted, and he couldn't reject me successfully because the environment was mine rather than his!

> Armed with my patient's name and many trepidations, I entered the pediatric ward. There were many empty beds, but the names weren't the right ones. Oh! Oh! I'll bet that sad little creature is mine! She is!

This participant had an unusual and frustrating experience when she approached the patient to whom she had been assigned. She was met with overt hostility and complete rejection by the 13-year-old girl, Jane. After making several attempts to initiate a conversation, the participant discussed the problem with her workshop instructor. At this point a decision was made to assign the nurse to another child. The object of the field experience was to enable her to establish a relationship with a relatively normal child and to analyze the interaction. Asking her to work against Jane's open and irrational hostility would be unfair and most likely too frustrating and anxiety-producing to facilitate learning. In addition, Jane's extreme hostility warned of complex emotional problems which were better explored by the permanent hospital personnel. This overt rejection of a visitor by a child was the only one of its kind in the total workshop field experience although a few participants experienced some covert rejection (mainly lack of response) during the initiation of the relationship. This incident, and the participant's sharing of her feelings afterwards in a class session of the workshop group, provided an opportunity to discuss a child's feeling of rejection when he meets an unaccepting adult.

Since the brief interaction between the workshop participant and Jane is not directly pertinent to the participant's subsequent interaction with another child, a full process recording is not included here; instead, the participant's expressed feelings are summarized as deflation, rejection, and a wish to be entirely removed from the field situation.

With 5-year-old Johnnie, however, she found a more positive experience.

| Nurse | Patient | Analysis |
|---|---|---|
| | (Handsome 5-year-old boy sitting in a wheelchair with a teddy bear. Greets nurse's approach with a grin.) | |
| Hi! What's your name? | Johnnie. | |
| Mine is Miss Jones. And does your teddy bear have a name? | He's Billy. | |
| That's a nice name for a bear. I wonder if you'd like to go for a ride down the hall? | Sure. | He's happy. |
| (Nurse wheels chair down the length of the hall and back.) | (Johnnie helps to steer wheelchair with considerable skill. Beams at everyone we meet in the hall. Seems to be known and loved very much.) | He certainly seems at home here. Must have been here for some time. |
| (Wheels chair out into solarium and spies a chalkboard.) Oh look! Here's a board and some chalk! Would you like to draw anything? | (Eyes sparkle.) Yes! | |
| (Pushes chair over to chalkboard and holds board in drawing position.) | (Johnnie takes a piece of chalk and writes his name and makes five marks on the board counting as he does so and crossing them with a sixth.) | |
| Boy! You write very well. Do you go to kindergarten? | Yes. Now I'll draw a house. (Speech is very babyish. Draws house with side composed of one large window, small window upstairs, front door with knob, curved walk, grass, chimney of bricks with smoke billowing out.) | Regression?<br>Wonder if he's the only child, or maybe the youngest? |

| Nurse | Patient | Analysis |
|---|---|---|
|  | There's a fire there. (Draws large tree beside house and carefully makes large hole in trunk.) | Why the fire? |
| What lives in the hole in the tree? | Men. | Father figure?<br>The hole expressive of aggression?<br>Should have said "What is the hole there for?" |
| Little men? | Yes, elves. And sometimes cats and dogs. | Maybe it was a mother figure! |
| Oh? Maybe some squirrels too? | Yes, or rabbits. (Contemplates drawing.) |  |
| What would you see if you looked in the big window? | Oh, buildings. | Evasion or misunderstanding? |
| I guess there are other houses around this one. Is this your house? | No. Rub it out. (Draws another tree with hole in trunk.) |  |
| (Nurse produces kleenex and erases board.) | Now I'll draw my brother. (Draws rectangular body, round head, legs and arms without hands or feet, eyes, nose and mouth, without ears.) | A little immature for a 5-year-old. |
| What's your brother's name? | Andy. |  |
| How old is he? | I guess he's 17. |  |
| Are all your brothers and sisters bigger than you? | Yes they're big. Can you play tic-tac-toe? | Prefers the center of the stage himself? |
| I sure can. | (Draws frame.) |  |
| Do you want the circle or the x? | The x. (Plays game intelligently and happily while winning. When nurse wins, he announces:) Nobody won that game! (Loses with better grace as games progress; nurse sees that he wins more than he loses.) |  |

| Nurse | Patient | Analysis |
|---|---|---|
| It's time for your lunch now. Let's go in and wash our hands. | All right. I beat a lot of games, didn't I? | |
| Yes, you did! (Wheels child into ward and helps him wash hands at sink.) | You dribbled that soap on my arm! | |
| Not a very good aim am I? | No.<br>(Wanted to get into bed to eat, but was told by student nurse that he could eat sitting up this time.) | Regression? Dependency? |
| (Nurse placed chair beside table. Only other child eating was Jane who nibbled a little at her sandwiches in a preoccupied way and soon took her tray back to the cart.) | (Johnnie ate a good lunch. Left tomato juice and ice cream but ate chicken sandwich, peaches, and milk.) I don't like cold chicken in sandwiches. | |
| I never heard of putting hot chicken in sandwiches. | We do at our house. | Oops! Implied criticism expressed! |
| Where did you feel bad, Johnnie, when you had to come to hospital? | At home. | |
| No, I mean, did your head hurt, or your tummy, maybe? | No. It was my feet. I can't walk on them. | |
| Do they hurt when you walk? (They certainly look pretty normal - no wasting or evident deformity.) | Yes, they hurt. I can't walk any more. | |
| Have you been here a long time, Johnnie? | (Smiles and holds up ten fingers.) | Ten days? Or is this his expression of a long time? |
| (New admission is seated at table to eat her lunch. Her name is Susan.) | | |

| Nurse | Patient | Analysis |
|---|---|---|
| Johnnie, this little girl is new here today and her name is Susan. | (Looks speculatively at girl and then gives her smile.) | |
| I've got to go now, Johnnie, but I'll see you again tomorrow. 'Bye! (He's certainly not heart-broken to have me go. Hope he'll be glad to see me tomorrow.) | 'Bye! (Concentrated on finishing lunch.) | |
| Second Day | | |
| (I entered ward and found Johnnie in his bed at the far corner of the room.) Hi, Johnnie! | Hello. (Seems pleased to see me. Hops around bed on all fours and then shows me some pictures he has pasted on construction paper. These are all Santas or Christmas card scenes.) | Does Christmas have special significance of is this just the kind of picture available? |
| Do you paste these pretty pictures up in the play room? | No. Do it right here. Stick this Santa on my shirt. (Opens drawer and removes roll of plastic tape.) | |
| (Nurse makes loops of tape to fasten Santa on shirt.) | | |
| Did you have any other visitors yesterday? | Yes. My daddy was here - and my mother. | Hesitation before mentioning mother. |
| That's wonderful. Do they come every day? | No (abruptly). | Why does he cut off this topic so positively? |
| Do you have some games to play? | No. Let's play tic-tac-toe again. | Why must he return to the isolation of the sun porch when other children are playing right here? |
| All right, we'll play for a little while. I'll get your chair. | | |

| Nurse | Patient | Analysis |
|---|---|---|
| | I need the urinal (this is said with such a babyish accent that nurse has to ask for repetition.) | |
| All right, we'll see about getting one for you. (Asks student to bring urinal. How humiliating to one's nursing ego!) | (There is a long pause while Johnnie uses urinal.) | |
| (After an unusually long time has elapsed, I approached drawn curtains.) Finished yet, Johnnie? | Yes. | |
| (Nurse opens curtains and returns to cubical.) All set now? | Yup. (Is just tying pajamas.) | |
| (Nurse wheels child out to chalkboard on sun porch.) | (Johnnie draws frames which today are large and expansive, running clear to edge of board. His playing is erratic and the the score-keeping even more so. He is still allowed to win most of the games, but becomes a little irritable when he is frustrated in completing a line. He indicated this by swinging arm in striking motion toward board. | Child is apparently not as happy as he seemed yesterday.<br>Is he using anger as a shield against anxiety of some kind? |
| I think maybe you'd rather do something else for a while. Can you draw me your favorite thing? | Yes! (Draws another tree. This time the tree has feet like a person.) | Why this thing with trees? This one with the feet is even more closely related to a person. No hole in the trunk today! |
| | Now I'll draw another kind of tree. (Draws triangular Christmas tree and covers it with ornaments.) | |

| Nurse | Patient | Analysis |
|---|---|---|
| That's one of the prettiest trees of all, isn't it, Johnnie? | Yes. (Scribbles over tree and erases it.) | |
| (Nurse at this point notices several eschar-like lesions on both of child's legs resembling healing third degree burns.) Johnnie, did you burn your legs? | No (abruptly). | Was yesterday's fire in the house related to a Christmas tree fire? |
| Let's go see what the others are playing now. | All right. (Turns to look up at nurse.) Are you coming back tomorrow? | What a good feeling to be wanted to return. |
| Yes, I'll come to see you tomorrow and the next day. Then for two days I won't be here. But I'll come back again after that for a few days. (Wheels child up to play table where other children are drawing and coloring. Aide comes to ask that table be cleared for lunch.) | | |
| | I want to eat in my bed. | Same idea he expressed yesterday. Is this a dependency symptom? |
| (Student nurse tells me that Johnnie is to have no lunch because he is scheduled for x-rays shortly.)<br>Johnnie, you are going to have your lunch a little later because you are going to have some pictures taken soon. | | If legs *were* burned, was there kidney damage? |
| Shall we play games on the porch while the others eat? | Yes. (Low voice.) Are you going to take me for my x-rays? | I wonder if these x-rays are painful? |
| No, I will have to leave in a few minutes, but you can tell me all about it tomorrow. OK? | OK. (Smiles) | Seems a little disturbed about prospect of x-rays. Becomes serious and thoughtful in contrast with previous gaiety. |

| Nurse | Patient | Analysis |
|---|---|---|
| (When I start to wheel chair toward porch, Johnnie takes over and propels himself rapidly across porch, striking opposite wall and breaking a leg rest on the chair.) | | Impulsiveness. Was this an escape reaction to x-ray? Panic? |
| Johnnie, I guess this chair is really broken. | We can fix it with my tape. (Turns chair and returns to bedside, taking tape from drawer.) | Suddenly very overactive. |
| (I tear off a piece of tape for child and let him attempt to fix the leg rest. Tape of course cannot support the weight.)<br>Guess we'll just have to use it this way. | (Johnnie settles back in chair.) | |
| | (On porch, Johnnie shuffles cards, deals a few and then abruptly says:) Let's get one of the other games. | Very distractable. |
| (We return to ward but Johnnie is unsuccessful at finding or borrowing a game.)<br>Here's a color book and some crayons. Want to use these? | Yes. (Returns to porch again and starts to color.) | |
| | (Conversation about brothers and sisters while coloring.) | Much less tense. |
| I must leave now. Do you want to stay here or go in with the others now that lunch is finished? | Want to stay here. (Coloring.) | |
| I'll see you tomorrow and then you can tell me all about your trip to x-ray. | (Smiles and nods.) | |
| 'Bye for now. | 'Bye. (Returns to coloring.) | |

| Nurse | Patient | Analysis |
|---|---|---|
| Third Day | | |
| | (Johnnie is waiting in the hallway in his wheelchair. Greets me with a gamin smile.) | |
| Hello there, Johnnie! You came to meet me this morning! | (Nods and wheels chair beside nurse toward ward.) I want to get into bed. (Hops from chair to bed and reaches into his cabinet for a story book.) Can you read this to me? | Why does Johnnie always seem to want attention which the group can't share? Probably that's the kind of attention he is missing most. |
| I sure can! (Reads one page of story, pointing to picture at appropriate times and asking Johnnie to point sometimes.) | (Shows interest in story for brief time then lays aside and pulls back curtain to see a class of student nurses meeting on sun porch.) | Johnnie's story listening capacity seems much less than a 5-year level. |
| Johnnie, you haven't told me about your x-ray yesterday. | (No response.) | |
| Did everything go all right? | Yes. (Pulling at pajama strings.) These pants are too tight.<br>(Opens drawer.) I want my drawing book. (Takes book and slides rapidly into chair striking right foot against chair arm.) Ow-w-w! I hit my foot! | Avoidance? |
| I'm sorry! All right now? (Wheels chair over to play table.) | (Draws two follow-the-number outlines.) | |
| I must leave for a few minutes, Johnnie so maybe you can color this picture while I'm gone. | Don't want to color. Just want to draw. (Has to have help with higher numbers.) | Don't leave! |

| Nurse | Patient | Analysis |
|---|---|---|
| (Another patient comes to help Johnnie with the numbers and nurse leaves to review Johnnie's chart which reveals that he has a circulatory and dermatological condition of the legs and recurrent urinary symptoms.) | | |
| | (Johnnie comes down hall in search of his "Jady.") Where did you go? | |
| Oh, I went for a walk. (Jane brings mail around and gives Johnnie two cards.) Thank you, Jane. Two cards at once! Aren't you a lucky boy! | (Opens cards hastily, looks inside each one and throws them down.) No money!! | |
| (I pick up cards and read messages to Johnnie.) Isn't this one from Betty pretty! | She's just a *baby*! (Hesitates a minute then picks up cards and kisses them.) Get *two* mails today! Let's play old maid. | Scornful.<br>From materialist to sentimentalist in such a short time! |
| (We play cards for a while, then return to tic-tac-toe on chalkboard. Lunch trays arrive.) | | |
| | Want to eat in bed! (Wheels chair beside bed, scrambles on bed and stands for a moment.) I can stand on my feet now! (Secures table from back of cabinet and sets it up.) | |
| (Nurse brings tray and helps put hamburger together.) | Will you be here after I have my lunch? (Eating.) | |

| Nurse | Patient | Analysis |
|---|---|---|
| No. I have to go very soon now. I'm going to leave you for a minute again, but I'll be back to help you fix your ice cream. | (Nods thoughtfully.) | Should have said goodbye right here. Somehow it's very hard to part from Johnnie! |
| (Nurse returns.) | (Johnnie is lying back in bed evidently in considerable discomfort.) I don't want any more. (Rubs tummy and writhes.) Want bed pan and urinal. | This was the third time I had left him today. Any relation to precipitation of G.I. discomfort? |
| (I remove tray.) I'll call the nurse for you. Johnnie, I'm sorry you don't feel well. Goodbye 'till tomorrow. | (Very sad little boy quite naturally had no farewell remark.) | |
| Fourth Day | | |
| (I stop in chart room before entering ward to get more help from Johnnie's chart. Apparently child's condition has improved much, for last urology note states that he may return home if next IVP shows no progressive problems. Johnnie's prognosis is good! I go to the sun porch where my workshop instructor is playing with Johnnie at chalkboard.) | | |
| Hi Johnnie. (Is he a darling! I wonder what my feelings would have been had Johnnie's appearance and personality been made repulsive by his illness.) | (Child peers around at me and smiles.) | I hope he hasn't transferred his attachment to my instructor! |

| Nurse | Patient | Analysis |
|---|---|---|
|  | (There is a conventional house on the board. Johnnie was asked to tell a story about the house but now erases it without comment.) 'Nother house. (Draws A-frame (?) house and puts in three rudimentary people.) |  |
| Who are they Johnnie? Some people you know? | (Just erases house. Proceeds to draw a number of combinations of triangles in geometric patterns, then erases.) | This fellow just doesn't want his private world invaded! |
| (How am I ever going to get any verbal clues from this little guy?) |  |  |
| Johnnie, why don't we each draw a picture of our own house and tell each other about it? | OK. (Draws the conventional house with two stories, a large chimney and much smoke.) There's a fire. | This fire always appears. At least now I know it has no basis in physical fact in a threatening sense. |
| Do you have a nice big fire place at your house? | Yes. (Erases both of our houses.) | Foiled again! |
| What shall we do? | I know! (Wheels self into ward and beside bed.) Look! (Has hand puppet on bed.) This is Arthur's. I gave him my Billy-Bear. Get my suitcase. | Yes, sir!! |
| (I put suitcase from floor up to bed.) | (Johnnie climbs up on bed, pulls everything from suitcase, sorts soiled clothing and puts it in compartment by itself.) When my mother comes, she'll take them home and wash them. | The handling of the clothes packed by his mother perhaps gives a little "feel" of love and home. |

| Nurse | Patient | Analysis |
|---|---|---|
| Will your mother be coming today? | No. Not tomorrow or the next day, but the day after she will come. Want to put these on. (T-shirt and briefs.) | |
| But won't it be awfully hot with two layers of clothes on? | No. You go'way while I change. (Pulls curtain for minute.) OK. | What ever will the staff think of the way I let him perform? |
| Boy! That was a quick change. | (Continues putting possessions in suitcase.) | |
| You'll be packing your things in there to go home pretty soon now, won't you, Johnnie? | (Nods head and closes suitcase.) | There must be a speech button someplace! |
| | (Holds hand puppet up to level with my face.) | |
| Well, hello! What do you have to say today? | (Just makes nodding motion.) | Like child, like puppet! |
| Could you tell me a story today? | | Maybe this will be good for a little talk. |
| | (In response to my request the puppet tweaks my nose quite vigorously.) | Just the response I always get symbolically when I ask for verbal returns!<br>Was I being too nosy? |
| My! I think you took off a piece of my nose that time! But how about telling me that story now? | (Johnnie starts out on "The Three Bears." Uses puppet at first, but lays it aside and just sits on the bed telling me the story with excellent expression. He leaves out parts of the story. | Probably the omissions have little significance considering Johnnie's short attention span, I am interested in the reappearance of the "three" again. There are three siblings in Johnnie's family; he draws triangular houses, triangular Christmas trees, three people in his triangular house; and now the story of "The Three Bears." |
| | (He ends his narrative.) Now let's go for a walk. | |

| Nurse | Patient | Analysis |
|---|---|---|
| That was a fine story! Thank you for telling it! | (Wheels self down hall and into side cubicle. Looks around in a friendly fashion but there is no apparent interaction with children there. Jane brings mail around. Holds back card from Johnnie playfully saying: "Is that you, Mr. Johnnie?") Yes. (Entering into fun.) That is me. | Seems to be good rapport between these two. |
|  | (Opens card and looks pleased with fuzzy bunny rabbit.) | Most of the cards Johnnie has received are about what one would pick out for a 3-year-old child. Perhaps this is a realistic allowance for the regressions of hospital experience. Perhaps the regression is in the eye of the beholder as well as in the self-image. |
|  | Let's take this back. (Returns to bed and places card with others. Spies small funnybook on table.) Will you read these? |  |
| Sure will. | Let's go out there. (Points to sun porch and then propels chair out there. Goes to far end of porch away from the other children.) Pull that chair over. |  |
| (I pull a chair over near his.) | (Reaches out and pulls my chair up against his.) Over here. Now read. |  |

| Nurse | Patient | Analysis |
|---|---|---|
| (I read very sketchily because child's mind is not on the story.) | (Gazes across room.) Want to do something else. (Places chair directly across room from mother sitting with arm around her little boy and looks at the pair with an expression of wistful longing.) | You poor baby! I can't give you that kind of relationship when I'll be leaving in just a few days. |
| (I turn and walk across porch.) | (Johnnie follows me right away.) | |
| Oh, here are the lunch trays. | | Saved! |
| | Want to eat in bed! (Rolls quickly to bed, climbs up, and sets up table.) | |
| (I have lost track of time as usual and am reminded that it is time to leave.) It's time for me to go again, Johnnie. Remember, I won't be here tomorrow or the next day, and I hope you have a nice lot of company while I'm gone. See you again after two days! | (Waves and smiles goodbye.) | |

During the weekend I found my mind returning to Johnnie so frequently that it was disturbing. My school children don't get to me like this. Matter of fact, Johnnie reawakens in me the frustrations of childlessness which had faded out of my consciousness about the same time I hit forty-five and the blessings of single independence began to outweigh its serious disadvantages! Maybe my school children should get to me more than they do. Is there a way to be "in touch" with a child without its draining one emotionally? I couldn't stand having multiple Johnnies on my mind!

Fifth day

When we arrive on the ward Johnnie is visiting in one of the side cubicles. As the others of our group enter the cubicle to visit their patients, he comes out in the hall to find me. He is dressed in shirt and shorts.

| Nurse | Patient | Analysis |
|---|---|---|
| Hi! You're all dressed up today! And your legs look so much better too! | (Smiles up at me and accompanies me down the hall, then to the chalkboard on the sun porch. On the board is a huge torso done in yellow chalk with a wild expression on the face, holding in each hand a large hypodermic syringe. Up in one corner is the title "Mad Doctor" and on one side in large letters is the word, "KILL." | Jane's work! |
| | I drew this! (Adds to the work around the eyes; scribbles over syringes.) | |
| You must have stood on a ladder to draw all this, Johnnie. | (He grins sheepishly, erases figure with my help and draws concentric circles.) | |
| Who came to visit yesterday, Johnnie? | My mother and my father---and my brother. I went down to the garden with them. | Seems very happy about visit. |
| Wasn't that fun! | (Turns board and draws a tall building with many windows.) | His impression of the hospital as seen from outside,yesterday. |
| How about drawing a picture of Mother and Daddy's car coming to see you? | No. | |
| (By this time much yellow chalk dust has gotten on Johnnie's arm and shorts. We go into the ward and I wipe off the worst of it with a damp paper towel.) | (Johnnie insists on changing his shorts. The suitcase is full of freshly laundered clothes brought from home yesterday.) | Why all these clothing changes? Is he too clean? |
| Just look at all the nice clean clothes Mommy fixed for you! | (Nods agreement. Pulls curtain to change shorts.)<br>You can stay in here if you want to. (Changes shorts.)<br>Here, fold these nice and put them away. | I'm honored! |

| Nurse | Patient | Analysis |
|---|---|---|
| OK. You'll be taking this little suitcase home with you soon. Does this make you feel good to think about going home? | Yes. | Should have asked: "How do you feel, etc."! |
|  | (Climbs back into chair. Spies Billy-Bear lying on play table. Grabs him and throws him up on the bed.) He has to go to bed. |  |
| Was he naughty? | Yes. | Illness interpreted as punishment? |
| Will he be good then after he has to go to bed? | No. (Rolls rapidly out of cubicle and becomes engaged in a wheelchair race with another patient. Then Johnnie continues on down the hall to side cubicle, back out to ward, and over to play table.) | I have distinct impression he is running away from me. It is upsetting to me at this stage, but maybe the break will be easier this way for both of us. |
| Isn't this a nice dump truck! | That's not a dump truck! It's a cow truck. See the cows in it? | Scorn. |
| Guess you're right, Johnnie (meekly). |  |  |
|  | (Lunch trays arrive and child again moves to bed for meal. Salts food too generously and then refuses to eat it. Plays with bread crust. Starts to pour salt on ice cream but stops when I make no exclamation. |  |
| It's time for me to be going. Johnnie, I'll be coming back tomorrow and the next day, then it will be time for me to go and you'll be going home soon too. | (Shakes head.) |  |

| Nurse | Patient | Analysis |
|---|---|---|
| Good bye, dear. | 'Bye. (Doesn't look at me as I leave.) | I never look back and wave to Johnnie as I leave. Why? Has that hurt his feelings sometimes? |

Sixth Day

When I arrive on the ward, Johnnie is walking in the corridor for the first time with the help of the nurse. Has very stiff gait and some difficulty in balancing. Acts half-afraid alternating with smiling around at onlookers. I stand in background watching, frankly jealous of his close relationship with the nurse. I feel like the mother duck when her ducklings swim for the first time. I was much more comfortable when Johnnie was more helpless. Nurse lifts child back into chair. Asks him if he wants to walk some more and he answers in the negative. Acts relieved to be back on familiar ground. Takes off slippers.

| | | |
|---|---|---|
| Did it feel good to walk again, Johnnie? | No. (Adjusts chair to his satisfaction.) | Not altogether happy about return to every day life? |
| Where to now? | (Rolls out on sun porch and up to chalkboard. | |

On the chalkboard there is a very cleverly constructed tissue mask complete with ties, taped to slate. Across mask are written the letters K-I-L-L once more. Jane is missing from the ward today. I go to call my workshop instructor to see the latest production. When we return, a very disgruntled child is starting in search of some attention.

| | | |
|---|---|---|
| | (Loses interest in chalkboard and visits with instructor for a few minutes. Propels chair into ward and toward corridor, ignoring me.) | I had just left him too. |
| (Instead of following I walk across ward and look out of window, then sit at play table with another patient and her visitor.) | (Johnnie comes over past table and plays with crank on bed. He rolls chair in beside bed and starts to dismantle a large card which has been on his table.) | |

| Nurse | Patient | Analysis |
|---|---|---|
| (I stand at the foot of his bed watching and suddenly realize I am rejecting him just because he was ignoring me.) Want some help? | Yes. | Relieved. |
| Won't you have a lot to tell your mother about next time she comes! She will be so proud of you! (Helping with card.) | (Nods.) | |
| | I want the urinal. Hurry! Hurry! (Clutching self.) | |
| (I bring urinal and stand outside curtain while he voids.) | Oh! Oh! | In pain. |
| Getting along all right, Butch? Still bothers some doesn't it? | Come. (Distressed look on face.) | I wonder if voiding actually causes as much pain as this, or if this is a good way to continue receiving concern. |
| (I take urinal out to nurse.) | (When I return, Johnnie is lying down, has pulled cover up.) Read to me. | Wants to be a baby again. Walking was pretty overwhelming in its implications. |
| Want this book? | Yes. Hold it this way so I can see. (Adjusts book.) | |
| (I just start reading when trays come.) | (Looks at food; scrapes sauce from spaghetti.) | |
| How many more days am I coming to see you, Johnnie? | (With teasing look.) Five? | |
| Nope. Only one more day, then I'll be going home and soon you'll be going home won't you? | Yes. | |
| Time to go again, Johnnie. Have a good nap. Good-bye! | 'Bye. (He is still eating as I leave.) | |

Seventh and last day

Johnnie is walking the length of the corridor with no help from the nurse when I arrive. Occasionally reaches for nurse's hand, but is told he doesn't need to be helped any more. He does not greet me - just seems to accept my being there.

| Nurse | Patient | Analysis |
|---|---|---|
| | (Climbs back into chair at end of hall. Seems happy about accomplishments today.) | |
| (I open porch door and help him into another chair which has brakes.) | Watch me go! (Runs up and down hall, making sudden stops with use of brakes. Goes into cubicle, looks around and then follows me up hall and over to play table. Sits pensively beside table watching card game.) | Why so quiet all of a sudden? |
| (I sit in chair beyond table.) | (Comes past me and motions to me.) I know. You can help me pack my suitcase. I'm going home today! (Hops up on bed, once again happy and gay.) | |
| (I lift suitcase to bed and then go to check with clerk on whether home-going is really true. It is!) | | |
| | Come back here! | |
| I'm coming! | (Selects shorts, shirt, and briefs.) Here, you fold these (pajamas) up. | |
| (I start folding clothes.) You're going home and I'm going home on the very same day! | | |
| Isn't that good? | Yup. | |
| | (Johnnie asks for urinal and then bedpan.) You can stay. | |

| Nurse | Patient | Analysis |
|---|---|---|
| I'll be back. | I want you to stay. | What he really dreads is having me off some place out of touch with him. |
| (I stand outside cubicle while he uses bedpan.) | (Seems contented with this arrangement.) | |
| | (Completes clothing change and goes to sun porch once more to change chairs.) | |
| I'll have to be going in a minute, Johnnie. | No. You can wait 'till she goes! (Points to other workshop member.) | Pretty canny! |
| OK. I'll wait 'til she goes. Why don't you go down the hall with me? | Yes! (Smiles up at me.) | |
| Now I'll go home and you'll go home. | You coming back? | |
| No, I won't be coming back. | I'm never coming back. (Free wheels in circles around elevator hall.) | Very relaxed and happy. |
| (Instructor asks who he is going to play with.) | My big brother, and my sister, and my little brother, and my mother and father.<br>(Circling around.) | First free mention of his family in home setting. |
| Oh! Oh! Lunch trays are out there Johnnie! Better get ready! 'Bye there! | 'Bye! (Looks like very exuberant child as he rolls down the hall.) | |

This nurse was somewhat more descriptive in her reporting of the interaction and more willing to express her own emotions in the process recording than many of the other participants. Nevertheless, the relationship between Miss Jones and Johnnie resembled, in large measure, those established by the rest of the participants. It was based upon conversation about immediate reality, the things which were of interest to the child at the particular time, the events which were occurring on the ward. It was not a counseling session with the nurse's responses designed to reflect or clarify the child"s expression of his feelings although this occasionally occurred. It was the kind of interaction that interested and sensitive adults frequently have with children of all ages. It was similar to those that school nurses carry on in their daily nursing practice. It provided in microcosm a sample of their style of relating to children which they could examine with the help of the other participants and the workshop staff. At the beginning of the interaction, both the nurse and the child often made tentative explorations. Upon examination of their process recordings, participants frequently noticed that they had asked many questions during this initial phase. They found that many of their questions were met with very brief responses on the part of the child, and information-giving answers. Several nurses remarked that they felt their excessive use of questioning was a way of coping with the anxiety of establishing a relationship with an unknown child, and with their ambivalent feelings about the entire field experience in the hospital setting.

As illustrated in Miss Jones" process recording, play was one mode of communication. Sometimes it helped the nurse and the child over the first awkward moments of the relationship. A toy or game often became the topic of conversation, perhaps a less threatening topic to the children than discussing themselves or their present situation. It often provided as well a measure of security for the nurse who was wondering "What should I say?" and "How can I make the child feel comfortable with me?" Many participants found that the child expressed a great deal about himself, his family, and his concerns in his drawings or his play with dolls or puppets. Their process recordings often reflected their attempts to study a child's play activities and to analyze the unique meaning of these activities in the life of an individual child.

As the relationship between the participant and child progressed, both seemed to develop some measure of trust in the other and confidence in the relationship. Some children devised ways of testing the nurse's ability and willingness to set limits on their behavior - as Johnnie did at various times. Occasionally subtle, nonverbal arguments developed as in the "you-ignore-me-I'll-ignore-you" episode on Miss Jones' fifth day with Johnnie. Some participants visited with older children who had well developed social relationships with other patients and staff, thus they had occasion to observe group behavior and patterns of leadership as they emerged.

Termination of the relationship proved difficult in some instances. Two or three days before the last visits, all the children had been told when the daily visits of the participants would terminate. The children often asked "Why?" but did not seem unduly disturbed by this as they were accustomed to the regular hospital volunteers coming and going at irregular intervals. Sometimes during the last day or two, a quiet drawing apart could be observed as the child turned more of his attention toward other people on the ward in preparation for the participants' departure.

For some of the workshop participants, termination of their relationships with the children were rather difficult. Several expressed a desire to return "on their own time" during the remaining days of the workshop; some wished to take a gift to the child on the last day as a token of remembrance. All such activities were discouraged by the workshop instructors. It was felt that a definite termination for which the child had been prepared and which would be uniform for all the children would be best for them. The nurses had encountered somewhat similar situations in their school settings. Obviously, some children with whom the nurse has worked closely move to another community or into other schools as they progress in grade level. The nurse must also occasionally be concerned with another type of termination - that which occurs when a child who needed to have a very supportive relationship with her becomes more self-sufficient. In this situation, too, the nurse must know how to "let go," how to help the child move to a more independent status when he indicates readiness. For these reasons, nurses in the workshop were asked to examine their own feelings about termination of their relationships with the children and to analyze their desires to leave gifts or send greeting cards to the children.

Group and individual conferences about the hospital visits and the process recordings were scheduled. Each of the four instructors was responsible for reading and commenting on the recordings of the five participants assigned to her. In addition, she had the opportunity to observe and converse with these five participants during their visiting periods with the children on the ward.

In the small group meetings, participants shared their observations of the children in the hospital and discussed their experiences. Various aspects of a particular child's behavior could be explored with emphasis on the manifestations of anxiety, the impact of illness and hospitalization upon the child, and his level of emotional and social maturity.

The participants' own reactions, both emotional and behavioral, were also a frequent topic of the small group meetings. One nurse might raise the question of how she might respond to a child's testing of limits; another might seek suggestions about communication with an extremely shy child; a third might want to discuss her own emotional involvement with the child and the problem of termination of the visits.

In general, the workshop participants had a very positive reaction to this kind of field experience. They felt that it gave them an opportunity to be more observant of a child's activities, to listen more closely to his conversation, to become more sensitive to his feelings, and to think about his behavior in terms of the principles of mental health and of growth and development that were presented in the workshop. Moveover, it provided the means whereby they could look more closely at their own emotions, reactions, and communication in a relationship with a child, and come to know themselves a little better.

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# Chapter IV

## ADVANCED WORKSHOP:
## CONDENSATION AND SUMMARY OF PROCEEDINGS

In the advanced workshop, the focus was shifted from the normal child with a developmental and situational difficulty to the child with a more serious emotional disturbance. The emphasis was upon early recognition of incipient mental illness and early referral for treatment. The school's role in treatment was seen as giving the child support in his interactions with various school personnel, and cooperating with the active treatment agency.

## PART I

### Process Recordings of School Nurse-Student Interactions

Participants left the first workshop with an assignment. During the subsequent school year, each nurse was to choose a child in her own work situation and keep a process recording of her interactions with that child over a period of three or more visits. The purpose of this assignment was to aid the nurse in transferring the skills and information she had gained in the first workshop into her particular school nursing situation. It was designed, too, to help her extend and enhance her ability to communicate with children and to analyze that communication.

The children that the nurses chose for their interactions differed greatly. They ranged in age from seven to eighteen years and were about equally divided between elementary-and secondary-school pupils. Girls were chosen slightly more often than boys. The family situations, academic achievements, and social adjustments of the children varied. Several nurses sustained a supportive relationship with severely disturbed students who were already in psychiatric treatment or who began a course of treatment as a result of the nurses' efforts in referral. In one instance, the nurse saw the child weekly throughout the school year upon the suggestion of the school psychologist who felt the child needed this kind of supportive relationship.

Many of the children the nurses chose for their interaction analyses had difficult home situations. One teenage girl, for example, carried heavy responsibilities for the care of the home and for the supervision of three younger siblings as her mother had deserted the family the previous year. In this instance, the nurse represented a mature, stable adult with whom the girl could share her concerns. A fairly large number of the children came from one-parent homes in which the mother or father had been lost through death, divorce, or desertion. Some were attempting to cope with parents who were problem drinkers, abusive, or seemingly uncaring; others were members of families that were continually struggling against poverty, unemployment, and marginal living conditions.

Most of the children the nurses chose initiated the contact with the nurse themselves. Some came complaining of such symptoms as headache or stomach ache which the nurses frequently hypothesized were of psychosomatic origin. Three such children were diagnosed as having school phobias. In these situations, the nurse frequently aided in the transition each day from home to school and provided security and support for the child. A technique which one nurse found useful was to enlist the child's aid in some routine activity each morning. After "helping" the nurse for a few minutes before class, the child was then able to continue with his usual school activities without overwhelming anxiety.

Scholastic achievement presented a problem for several youngsters with whom the nurses worked. One fourth-grade boy responded to academic pressure with severe headaches. Together with the nurse he explored his feelings and problems in the classroom, began to see the relationship between his fears and his physical symptoms,and took constructive steps to secure help with his school work from his teacher.

Among the adolescents with whom the nurses worked, several were in a relatively normal stage of disagreement with parental opinions and standards. Here, one nurse was helpful in assisting a teenage girl to see her father as an individual who was deeply concerned about her welfare rather than a stern, unfeeling disciplinarian. Several adolescents were having difficulty in heterosexual relationships. One girl feared she was fulfilling her mother's prophesy of promiscuity; another covered her feelings about being unattractive under a veneer of superiority; a third found she was pregnant although unmarried. In this last instance, the nurse aided the boy and girl and their parents to work out a satisfactory solution to their dilemma.

Obesity was a real problem for several children. The nurses worked with these children in various ways, sometimes encouraging them to join a group of overweight youngsters who supported each other in weight reduction; sometimes aiding with information about nutrition; and always attempting to provide support and acceptance whether the scales went up or down.

In analyzing their interactions, the nurses in the workshops were encouraged to express both their own reactions and feelings and their observations and interpretations of the children's responses. After they had recorded the conversation and nonverbal behavior as accurately as they could, the nurses were asked to identify those behaviors which either enhanced or inhibited the interactions. Examples of some of the most frequently identified behaviors follow.

Enhancing the interaction. During the first workshop, the nurses had become aware of the kinds of statements and questions which are most likely to encourage a child to express his feelings and ideas, and those which tend to cut off communication. Many nurses attempted to make greater use of open-ended questions. "How do you feel about it?" and "How are things going for you?" were found to be more productive than "Isn't it nice your grandmother's coming to visit?" and "Are your grades any better this time than last?"

Listening for the feeling tone of a child's statement proved helpful in providing cues to understanding what he was really trying to convey. For example, a boy who was having difficulty in both his family and peer relationships was describing his experience in swimming at a recreational club: "My father lets me use his Navy towel!" The nurse responded to the feeling he was conveying rather than to the informational content with, "That's very special, isn't it?" Incidentally, in this situation the nurse had assisted in providing a free membership in the club for this youngster.

In their interactions, the nurses attempted to keep the focus of the conversation on the child and his concerns. In the following vignette, the nurse may have been tempted to inquire about the behavior of the child's mother. However, realizing that the crucial matter is not the mother's behavior but how the child feels about her mother's behavior, she maintains the focus on the child and encourages her expression of anxiety:

Student: Well, you know, like my mother and father have awful fights sometimes and they yell and scream and when my grandmother comes I really like it. But whenever she and my grandfather come my mother always has to start something. She won't just leave us alone for a minute and she gets these terrible migraines and has to go to bed.

Nurse: And you feel . . .?

Student: Well, like all funny inside and scared and I don't know why I feel so awful and everything is all so bad and I get so mixed up kind of.

Subsequent conversation revealed that the child felt in some way responsible for the family strife and the nurse was able to give her some reassurance that this was not the case.

Another nurse found that the simple technique of repeating part of the student's statement was sufficient to encourage her to continue:

Student: Dr. Brown gave me some birth control pills to help regulate my periods and my backaches but when my dad saw what kind of pills they were he took them away from me.

Nurse: Away from you?

Student: I didn't take any! He was just furious and said no daughter of his was taking those kind of pills. I don't know what he thought I was going to do. I guess he doesn't trust me!

Nurse: What do you mean, trust you?

Student: He thinks this illness is all in my head or something.

Nurse: And how do you feel?

The conversation about the girl's feelings of frustration with her physical symptoms continued. Eventually, she was hospitalized for tests and diagnosis, and treatment satisfactory to both the student and her family ensued.

Observation of a child's posture, facial expression, and other nonverbal behavior often gave the nurse indications of the child's emotional state before the conversation began. To aid in increasing their acuity in observing nonverbal behavior, the nurses were encouraged to describe the behavior of the children with whom they worked as well as the conversations they had with them. One wrote:

> John came to the office about 10:00 A.M. He sat in a chair in the corner of my room. He burst into tears, dropped his head lower into his lap, his hands wringing out his handkerchief all the while. "I just don't know what's wrong," he said. His voice was raised to a higher pitch than usual. His eyes were glassy and he resembled a wild animal trapped.

The nurse interpreted John's nonverbal behavior as indicative of extreme anxiety, a near-panic state, and she took steps to provide verbal and nonverbal reassurance and support.

Another nurse felt that deviation in a child's behavior was significant:

> Mary's face was flushed, her tiny hands moving about restlessly. Many oral twitching movements were evident. She was usually a placid, almost stoic child. These signs of emotional distress did not usually accompany her complaints.

Later interaction revealed that increasing parent-child conflict appeared to be one source of Mary's difficulty. The nurse was successful in helping this family obtain professional counseling at a local mental health center.

As the nurses attempted to observe the children's nonverbal behavior, they also became more aware of how their own nonverbal behavior can communicate support to a child.

Ann was a 9-year-old child who had difficulty controlling her hyperactivity and aggressive behavior:

The nurse heard a child screaming and crying in the hallway. It was Ann kicking at the wall and sobbing.

Nurse: What is the matter, Ann?

Ann continued to sob but less loudly. They went toward each other and the nurse led Ann by the hand into her office.

Nurse: Care to lie down?

Ann continued to cry. She sat on the cot wiping away her tears. The nurse held her for a while. Finally Ann stretched out, then curled up, thumb in mouth, and fell asleep.

In this situation the nurse, realizing her questions were not effective, used touch, taking the child by the hand and holding her, to communicate reassurance. Ann responded by relaxing in what she felt was a safe environment.

An older child, however, is often able to explore verbally an event which worries him. In working with 14-year-old Bill, the nurse was able to help him express his fears and test them against reality.

Student: Everything's wrong!

Nurse: Everything?

Student: Yeah, I'm so worried about my aunt. She's having an operation today and it's awful serious. And my mom is so upset - she's afraid my aunt will die. She has a "bad heart" and they don't want to operate but they have to. Everything is wrong.

Bill sat on the edge of the couch, head down in a slouched posture. His hands were clenched tightly. His voice shook, and the volume rose and fell sporadically.

Nurse: I'm sorry your aunt needs surgery, Bill. It's a frightening experience for everyone. (Arm around Bill's shoulders.)

Student: It sure is! (Looked up, distressed.)

Nurse: You know, you're understandably concerned and anxious about your aunt. And it's hard to see your mother so upset, isn't it.?

Student: Oh, yes. And you know my mother has a bad heart. I'm scared that she'll get sick.

Nurse: Bill.

Student: Yes. (Sat up straighter.)

Nurse: How has your mother been feeling?

Student: Good, I guess. She hasn't had any of those chest pains or any shortness of breath for a long time.

Nurse: That's really very good, Bill, don't you think?

Student: It sure is! She used to get red-faced just going up the stairs. But, lately she's afraid about my aunt and . . . (Brightened at first, then clouded up again and left the sentence dangling.)

Nurse: Of course she's upset about your aunt. That's normal, isn't it?

Student: Yeah . . . .

Nurse: Well, then, the important thing is that your mother, although upset, is feeling and looking well.

Student: Yeah, I guess so. (Thought a few seconds before answering.)

Nurse: And she isn't having the chest pain and shortness of breath now.

Student: Hey, that's right. (Almost smiled.)

Bill seemed to be concerned about two problems. His aunt's illness and the possibility of her death worried him but even more, he seemed to fear that his mother would become ill and possibly die. While the nurse accepted Bill's expressions of concern she was able to reassure him by helping him realize that the fears about his mother's health were not supported by objective evidence of physical symptoms.

Tom, a fourth-grade pupil, seemed to need a great deal of encouragement. He found his school work difficult and frequently sought refuge in reporting to the nurse's office with a headache. After the nurse had established a friendly relationship with Tom over a period of several visits, he began to discuss his school problems with her.

Student: I get all confused about math. Then I get scared. Sometimes I can't even think.

Nurse: Why are you scared? Of what?

Student: Oh, that I'll make a mistake and Mr. Brown (the teacher) will yell at me.

Nurse: Has he ever yelled at anyone for making a mistake?

Student: No, but he might at me.

Nurse: Tom, why don't you ask Mr. Brown to give you extra help with your math? I'm sure he would if he knew you didn't understand.

Student: Maybe I will. Do you really think he won't be mad?

Nurse: Yes, I do.

Tom accepted the suggestion and later reported: "He doesn't get mad at me when I make a mistake. He helps me to see what I did wrong."

In this situation the nurse was taking into consideration her prior knowledge of Tom and his teacher. She knew Tom's teacher as a patient young man who would be eager to give Tom extra help. She knew Tom as a rather timid boy who would be unwilling to approach his teacher without encouragement. By helping Tom clarify his situation, and suggesting appropriate action, the nurse was able to affect some change in the situation which contributed to his anxiety and hence, very probably to his headaches. As in all nurse-student situations, she might have chosen an alternative action. For example, she might have thought it would prove fruitful to follow up Tom's comment, "He might yell at me." Why did Tom feel he might be the object of chastisement when he had never observed his teacher behaving this way?

In subsequent interactions with the nurse Tom eventually recognized the connection between his worry about his school work and his headaches. He ventured the opinion: "I think when I get upset and my head aches, I just need to relax for a minute. My head hurts 'cause I'm upset." Through his teacher's help and the support of the nurse, Tom's headaches became less frequent.

Children frequently must face minor situational crises. Fourteen-year-old John was perhaps more vulnerable to such crises than most children as he and his mother were part of a group of impoverished people who moved frequently from town to town. At the time of his entrance into seventh grade, he and his mother were sharing a house with three other women and their children. Although John was new to the school, the nurse had established a good relationship with him by obtaining treatment for a physical health problem he had. When he came in one day and enthusiastically told her about the dog he had found, she sensed disappointment ahead for him. In addition to the fact that the dog had obviously been lost by its owner, she knew John would face difficulty in the form of his mother's disapproval and the expense of caring for the dog even temporarily. She attempted to forestall John's disappointment by involving him in a problem solving project which proved to be successful and resulted in an ego-boosting experience for him.

> John enters and tells the nurse he has found a dog and plans to keep him. Discussion ensues in which it is revealed that the dog has a license tag. The nurse suggests that perhaps his owner is missing him very much.
>
> Nurse: What would you want done if someone found your dog?
>
> Student: I dunno - guess I'd want him to look for me and bring the dog back.
>
> Nurse: Let's make a plan to find his owner. How do you think we should go about it?
>
> Student: Gosh, I dunno - maybe call the police.

Nurse: At recess time you can come back and call the police to tell them about it. You may use the phone on my desk. Their number is on the dial, OK.? I may not be here but I'll see you before school ends. (Nurse's thought: Perhaps if he is instrumental in returning the dog to its owner some of the lost feeling will go. I want him to do it himself. I know he should call the dog officer.)

Later in the day:

Nurse: Tell me what you found out at recess, John.

Student: I called the police and they told me to call the dog officer. I called him and he gave me the name of a man to call. Can I call him now? (He seemed pleased that he had talked with the police and the dog officer. Something to talk about with his classmates.)

Nurse: Go ahead. (The result was that the man had just returned from Vietnam and had bought the dog for his wife. He was delighted to find him again and told John he would go to his house about 4 o'clock to pick the dog up. The dog and owner were reunited and John had $5 reward. He went out and bought a basketball.)

Later process recordings revealed that John became increasingly interested in basketball. The physical education department helped him and eventually he became manager of the basketball team.

The nurses were asked to describe their own reactions to the children with whom they worked and to the conversations they had had with them. Several nurses chose to keep process recordings of their interactions with children to whom they responded somewhat negatively in an attempt to discover the basis for their feelings. One nurse described her reaction in this manner:

> For some reason, her visits became increasingly irritating to me. I'd find excuses to leave the office, making her return to the hallway, or I'd interrupt her to take care of other students who came in; or I'd deliberately go to the office during her lunch hour.

The nurse attempted to analyze her irritation with this student. She felt that some of it began with the student's preoccupation with a cake she had baked for a Future Nurses' Club meeting. The nurse wrote: "An excessive need for praise? Mine, too?" She further hypothesized that the student's continued daily visits during the lunch hour and the repeated references to the cake episode could have aroused her own anxieties about being overweight. In addition, the visits interrupted the nurse's lunch hours and anticipated discussions with teachers during the meal. The nurse also observed: "I also get irritated with people who talk a lot. I used to!"

Thus, the nurse recognized some of the reasons for her response to this child: the increase in her own anxiety in relation to her obesity; fear that the student might have a "crush" on her that she would not be able to handle; and the student's talkativeness. By analyzing her own feelings and reactions, she identified the sources of her anxiety and was able to modify her own behavior toward the student, to respond more positively to her, and to maintain a supportive relationship with her.

Inhibiting the interaction. When the nurses looked critically at their own conversations with students they recognized various ways in which they had been inhibiting the interaction. They noticed that sometimes their end of the conversation consisted of a series of questions. A student would enter with a physical complaint and the nurse's response might be designed to elicit such direct information as: the duration of the symptom, its severity, associated events, and so on. The student usually responded by providing the information the nurse requested but offering little comment on what he saw as significant or perhaps disturbing in his situation.

The following excerpt is illustrative of the conversations which sometimes took place:

Nurse: What can I do for you Jim?

Student: Well, after I eat, my stomach seems empty like I haven't eaten at all.

Nurse: Did you eat breakfast?

Student: Yep.

Nurse: What did you eat?

Student: Cornflakes.

Nurse: Did you use milk on them?

Student: Yep.

Nurse: Does it bother you now?

Student: Yep.

Nurse: How does it feel?

Student: Like I haven't eaten--empty.

Nurse: Have you been feeling this way long?

Student: About two weeks.

(Nurse checked temperature--normal. No symptoms of acute distress.)

Nurse: I'd like to see you after lunch.

Student: OK. (Left the nurse's office.)

One might well ask what the student was really communicating here. What did his repeated statement that he felt "empty" imply? Various factors - some nutritional, some physical, some emotional - might conceivably contribute to this student's difficulty. One might speculate on the presence of a significant cue in the student's expression of his feeling of "emptiness" and perhaps hypothesize the recent loss of a person of importance to him. On the other hand, his symptom might be linked to insufficient dietary intake for a growing adolescent, as the nurse seemed to assume. Further exploration would appear to be indicated. Questioning was obviously minimally productive, eliciting at best a brief statement and often a simple "Yep."

The nurses frequently noted that they were apt to focus rapidly on a physical symptom in preference to signs of a problem of a different nature. In workshop discussions, they noted that they often feel more comfortable dealing with a physical symptom that can be objectively observed and perhaps alleviated by appropriate nursing action. Cues to emotional difficulties are often more subtle, more subjective, and indicative of problems less amenable to rapid treatment.

In the following example, the nurse was engaged in a conversation with an adolescent girl who had a minor orthopedic handicap of the lower extremities.

Nurse: What don't you like about school?

Student: Oh, I don't know; I don't like gym.

Nurse: Tell me about gym.

Student: Miss Jones makes us do all kinds of things and my legs hurt. I hit my toe the other day.

Nurse: Let me see your toe.

Here, after her open-ended remark, "Tell me about gym," which seemed to have a positive effect on the student's expression of her difficulty, the nurse narrowed the focus to a physical symptom which the student had mentioned, thus cutting off or inhibiting further conversation about the student's problem in physical education, in school, or in general.

Other comments or questions which served to inhibit the nurse-student interaction by cutting off the student's expression of his own ideas and feelings were recognized by the nurses. Changing the subject is one inhibitor as these two examples demonstrate:

Nurse: Tell me how your school work is going?

Student: I hate school.

Nurse: What kind of work do you think you're going to want to do after you finish school?

- - - - - - -

Student: He's (father) really terrible. When he drinks he fights with us and when he isn't drinking he's sick and we don't dare make any noise. I could kill him.

Nurse: How many are in your family?

It is interesting to note that the nurses in each of these interactions changed the subject immediately after the student had made a strong statement of feeling: "I hate school," and "I could kill him." Perhaps their own anxiety at these points in the conversations made it difficult for them to explore the students' feelings with them and they felt impelled to cut off the expression of a threatening emotion or to alter the course of the conversation.

A similar but more subtle kind of diversion of focus from the student and his feelings to other topics was recognized in the following excerpt:

Nurse: Do you have friends who go to the club?

Student: No, John Smith is my friend but he doesn't go to the club.

Nurse: What does John do in the afternoons?

Here, while seeming to pursue a subject raised by the student, the nurse inadvertently shifted the focus of the conversation away from the student and his problems in social relationships. She responded to the overt content of the conversation, rather than to the feeling the student was conveying.

Occasionally, the nurse may make a remark that is threatening to the student because it implies disappointment in him or criticism. The following conversation took place between a nurse and a student whose teacher (whom he likes very much) was absent from school.

Nurse: I hear Mrs. Jones is sick and not able to be here today. Do you have a substitute teacher?

Student: Yes, we have a substitute and she's awful. She's messed up the whole class. I'm leaving.

Nurse: George, what are you doing about it? How would Mrs. Jones feel about this?

In this situation, one might speculate that perhaps the student was feeling the absence of his admired teacher as well as reacting to possible confusion or changes in his class environment. Often the expression of feelings such as these in the presence of an accepting individual must preceed an attempt to cope with a problem situation. By her response to George, however, the nurse implied that he was wrong to feel and react as he did and that his teacher might be disappointed in his behavior. In addition,by turning the focus of the conversation away from George's feelings to those of his teacher, the nurse's comment served to inhibit their further exploration of the real problem.

Implied criticism is also illustrated in the next example although here the nurse recognized that she inhibited the conversation by disagreeing with what the student had said:

Nurse: How are things going in school?

Student: Not too well. I think my teacher is mad at me.

Nurse: Probably not mad. She probably feels you could do better.

In this instance, the nurse sought to reassure the student that his teacher was not angry with him by interpreting to the student his teacher's behavior. In the attempt, however, she contradicted his perception of the situation and lost the opportunity to respond to the student's feeling of being the object of his teacher's anger.

Contradiction, the nurses found, played a part in inhibiting other interactions. In the following incident, the nurses's attempt to reassure might have had the opposite effect:

Student: I don't have any friends.

Nurse: But you have wonderful friends. Do you know who they are?

Student: I haven't any friends.

Nurse: Mr. Brown (the principal) is your friend. And Mrs. Smith (his teacher) has tried very hard to be your friend. She's a wonderful person.

Contradiction of an individual's perception of the situation connotes a lack of acceptance of his feelings in the situation. Perhaps this student's principal and teacher have made extraordinary efforts to reach him but the child has stated that he doesn't think anyone really cares very much about him. It's his perception and his feelings that are significant and these are seldom changed by a simple contradictory statement made by another person.

Telling a student what he should or should not do, or giving lengthy expositions which state or imply that his actions are wrong, was labelled "preaching rather than teaching." This was discussed in both the first and second workshops and participants sought to identify "preaching" in their own process recordings:

Student: Mom and Dad are fighting all the time and I think they are about an inch away from divorce. It's terrible. They yelled all night last night and my friend next door work up and heard it, that's embarrassing!

Nurse: You know, Joe, we can't pick our families and we all have problems from time to time. But usually it's hard to do better with a different parent or child. The best we can do is look at what we have and try to see what we can do to improve the situation. Now, Mom and Dad fight a lot over you

> kids so maybe you can help. Try to avoid doing things that cause arguments. Don't complain about Dad to Mom. Try to find reason to praise him. Your biggest problem to work out is getting along with your stepbrother. If you can solve that, half your battle is licked. But only you can do that.

This particular student was obviously concerned about parental conflict and possible divorce. One might suspect that he was struggling with feelings of insecurity, mixed loyalties, and perhaps guilt arising from any real or imagined contribution he may have made to family strife. The response of the nurse, however, cut off any exploration of these ideas and perhaps reinforced feelings of guilt, since she herself mentioned this in the conversations as a possible source of parental disagreement.

One nurse, when talking with a student who wished to drop out of school, found the conversation inhibited by her own premature interjection of reality:

Nurse: What do you plan to do with yourself when you drop out?

Student: Oh, I'd leave home, get an apartment and hang around the center city.

Nurse: Do you have any friends there, or have you ever been there?

Student: I have one girl friend who goes there. My mother won't let me go any place. I like hippies, so I'd like it there.

Nurse: If you drop out of high school you probably couldn't get a job that would pay for an apartment and food.

Student: I wouldn't mind being hungry. I don't want to live home and I hate school. I don't know the difference between a verb and an adverb.

Nurse: But, food is important to your health.

The student in this situation seemed to be communicating a wish to escape from what she felt was an unrewarding and dissatisfying life situation. She seemed to desire to flee from home and school rather than flee to life among the hippies. The interjection of practical reality at this point might well have closed one more door to her and accentuated her feelings of being caught in her present situation, rather than helping her to deal openly with those things that were troubling her and to find realistic alternatives.

## Evaluating the Nurse-Student Interaction

Each nurse attempted to analyze her own interaction with a student prior to sending the process recording on to her instructors. Toward the end of the second workshop, the participants were again asked to review their recordings. In the interim, two instructors had read the written recordings, had made notes of their comments, and had scheduled appointments to discuss the recordings with the participants.

To aid both nurses and instructors in systematically viewing the process recordings, a review sheet was drawn up. (see Appendix, p. 199). Some of the particular points listed for consideration were: the initial contact with the student; the activities of the nurse; the verbal exchange; the degree of involvement with the student; and the nature of the termination of the interaction.

Virtually all participants in the workshop voiced the opinion that keeping process recordings of nurse-student interaction was helpful to them. Some indicated that the process recording helped them identify characteristic responses or patterns of communication in their conversations with students which had had an inhibiting effect on the interactions; others said that it sharpened their skill in observing nonverbal behavior; many felt that it had increased their insight into themselves and the particular student with whom they had worked.

The instructors found the process recordings to be most interesting material. In addition to their usefulness as a teaching tool, they reflected the wide variety of students and situations that school nurses encounter in their work. Some of the recordings indicated that the nurse, the student, his family, and the school had made considerable progress in dealing with difficult situations; others reflected the frustration that frequently arises when problems seem stubbornly complex and difficult to resolve. One observation that must be made, however, is that in spite of frequent handicaps in lack of time, privacy, communication skills, and sometimes even understanding, the majority of these nurses had established meaningful relationships with students. In whatever manner, their concern and caring for the students seemed to be communicated, and the students responded by repeatedly seeking the nurses' support and by sharing their problems with them.

## PART II

### Primary and Secondary Process Thinking

In order to provide a common frame of reference for all workshop participants, the development of logical thinking and the use of mental mechanisms were reviewed. Two types of thinking were defined: primary process and secondary process thinking. Primary process thought was described as being the kind characteristic of young children. It is never quite abandoned by the developing individual, however, and is also found in the dreams of the adult. Primary process thinking has little relation to what we call logic. It can be characterized as being generally wish fulfilling rather than oriented toward reality. It is also filled with many generalizations, many displacements of a characteristic of one object to another, and exaggerations. Repetitiveness and distortions are common. Primary process thinking was also described as being highly symbolic, with many ideas or thoughts being condensed and expressed by a single symbol. Often in mental illness there is evidence of this kind of thinking. The patient's symbolic communication may seem illogical to the staff, thus it becomes necessary to decode the patient's message and to check frequently to see if his communication is being understood.

Secondary process thinking develops as an individual matures. We commonly think of it as adult logic. This kind of thinking is logical, rational, and coherent. It is built upon a firm basis, and there are logical connections among ideas. The development of secondary process thinking is highly dependent upon the development of language in the child. When objects and actions can be symbolically represented by words, they can be more logically arranged and connected. Memory development and the ability to test reality are also major influences on the development of secondary process thinking.

### Mental Mechanisms

Some workshop participants were familiar with mental mechanisms under the name of "defense mechanisms" or "mechanisms of adjustment." The purpose of the mental mechanisms is to defend the personality (the ego or self-system in some schools of psychiatry) against amounts of anxiety too great to handle. They are necessary and normal means of coping with reality. As the child grows, he encounters reality. As his memory improves, he remembers both pleasant and unpleasant things and his anxiety level rises. Anxiety serves a useful function in learning and in socialization, but if it becomes too great for the individual to handle it can be destructive and perhaps result in mental illness. Mental mechanisms are alternative ways of coping with this anxiety.

A summary sheet on mental mechanisms was prepared for the participants on the basis of material adapted from four primary references: American Handbook of Psychiatry; Personality Development and Psychopathology; The Psychoanalytic Theory of Neurosis; and The Psychiatric Dictionary. (1-4) Items included on the summary sheet were:

Introjection - symbolic incorporation in which something outside of the ego is perceived as being inside. A process of assimilation.

Projection - unconscious opposite of introjection. Something inside the ego is seen as being outside. The individual attributes his own wish or impulse as belonging to others. This is normal in childhood.

Identification - (includes imitation). May be partially conscious, taking on the characteristics of a loved person or someone who is feared. Sometimes accomplished by introjection.

Suppression - consciously pushing unwanted ideas from consciousness. "Don't think about it."

Repression -(from inside). A major defense mechanism - unconsciously pushing unwanted ideas from consciousness. Amnesia is related to repression.

Denial - may be partially conscious. Pushing away unpleasant situations from the external world and substituting wish fulfilling fantasy. Seen normally in very young children.

Reaction-formation - unconscious. A type of repression. One of a pair of ambivalent attitudes is made unconscious and there is overemphasis on the opposite one.

Undoing - unconscious. This is usually ritualistic. Undoing a wrong through suitable performances or deprivations. The performance is usually the opposite of what the person has done, or a repeating of the performance but with a different attitude.

Sublimation - unconscious. Modification of the impulse to conform to the demands of society. The impulse is channeled into acceptable behavior.

Regression - the act of returning to some earlier level of adaptation. Usually associated with fixation.

Isolation - separation of an idea or memory from the feelings associated with it.

Each mental mechanism was discussed in turn. Some additional comments were made to supplement the dittoed material. A point of emphasis was that mental mechanisms are not mutually exclusive. Often two will be used at the same time.

Introjection was identified as one of the major mechanisms through which the young child learns. It is often closely associated with identification. For example, a child identifies with one or both of his parents and perceives some of their characteristics as characteristics of himself.

Identification is another mental mechanism through which the child learns. He grows through identification with his parents and other adults. Identification may take place even if the one with whom an individual identifies is hostile and antagonistic toward him. Bettelheim reports his observations in Nazi concentration camps in which some of the prisoners identified with their guards and took on their characteristics. (5) Identification often takes place in part rather than in toto; identification with specific characteristics of another person, for example. Occasionally this takes place after the death of a beloved individual. The one who remains takes on the characteristics of the one who has died. This is generally regarded as unhealthy identification since it makes the working through of the grief process more difficult. Actors commonly use identification; sometimes they have so identified with the part they have played that there is a feeling of emptiness or loss of personality when the role ends.

Scarlett O'Hara provides a good example of the use of suppression. "I'll think about it tomorrow." Lillian Roth epitomizes the same thing in her book title, I'll Cry Tomorrow. Suppression, too, may prevent a person from really working through his negative feelings, experiencing them, recovering, and moving to a happier state.

An example of denial may be seen in the case of a mother who seems not to understand that her child is in difficulty in school. She has shut out something that is too anxiety-producing for her. School personnel sometimes make the mistake of raising their voices and using strong language which tends to increase her anxiety and intensify the problem. Instead, if some way could be found to allay her anxiety she might be helped to cope with reality more constructively.

Reaction-formation may be the mechanism used in dealing with anxiety-producing ambivalent feelings. An example of this might be found in the toddler who is overly kind to his newborn sibling. His feelings of hostility are repressed and he overemphasizes his feelings of affection toward the infant. An understanding adult can help him learn that it is permissible to feel anger and to express it in socially acceptable modes.

Sublimation is thought of as one of the healthiest of the mental mechanisms. When an unconscious impulse is channeled into acceptable behavior, the individual's energy can be devoted to more constructive behavior.

Temporary regression is normal in young children. Students were referred to a book by Anna Freud, Normality and Pathology in Childhood (6), which includes an assessment of the normal child. This author illustrates the idea that normal mental development is composed of both progression and regression, two steps forward and one step backward, in a sense. Moreover, the child may progress in some areas of his development, stay the same in others and regress in still others. The kindergartner, for example, who is learning to separate from his mother and developing his ability to get along with other children, may temporarily regress in toilet training. Temporary is a key word here. Temporary regression is normal. Permanent regression is not. Regression may occur in virtually any area of development. For example, a child may regress from secondary process thinking to primary process thinking, in social adaptation, in reality testing, or in his ability to master anxiety. Regression is most commonly observed during periods of stress in a child's life; when he is ill, for instance. An understanding of the mechanism of regression helps one to comprehend a child's behavior and to formulate realistic expectations. A child may function at a high level at one point, but it does not necessarily follow that he will continue to exhibit this behavior.

The differences between regression and fixation were delineated. Fixation refers to remaining on the level of development already achieved and not progressing further because of the occurrence of a traumatic experience. A traumatic experience to a child may be excessive frustration or, in certain instances, excessive gratification. An example of the latter would be an instance in which a child finds one stage of development so satisfying that he does not desire to move on to the next. Learning depends on at least a minimal level of anxiety. In the normal course of development, the anxiety present is sufficient to motivate learning and progression into the subsequent stage.

It was reemphasized that the mental mechanisms are necessary defenses against anxiety. In fact, reinforcement of mental mechanisms may be especially necessary in children to protect the personality from disorganization. Each individual needs to have access to a variety of mental mechanisms. Sullivan sees mental illness as complete dependence on only a few.

## Treatment Modalities

Many methods exist for aiding individuals in maintaining mental health. The following categories are not mutually exclusive; in fact they often overlap. They are described in Wolberg. (7)

Education, historically, was thought of as being concerned with the development of the intellect. But as the importance of considering the needs of the whole child became understood, the significance of interpersonal relations in the learning process was recognized. The philosophy of education was then extended to include emotional and social as well as intellectual learning. Thus education and psychotherapy have a common objective, the fostering of personality growth and adjustment. In education, this objective is attained through the relationship between pupil and teacher; in psychotherapy, it is achieved through the relationship between patient and therapist. In both, the relationship with an accepting person is of prime importance.

In social casework the worker provides social services of which the client is in need. Generally, social workers aid persons who are experiencing a breakdown in their capacity to cope unaided with their own affairs. The aim is to help the client to mobilize his inner resources in order to cope with his present situation.

Counseling may be practiced by members of various professions: social work, psychology, education, or religion, for example. It is a form of interviewing in which the client is helped to understand himself more completely in order to correct an environmental or adjustment difficulty. Some types of counseling are organized around circumscribed goals; others are similar to psychotherapy. An example of the former might be vocational counseling in which the goal is to help the client to identify an appropriate vocation. An example of the psychotherapeutic type might be counseling with the goal of aiding the client to free himself from inhibitions or distortions, to seek satisfaction as well as security.

Guidance is the term given to a number of procedures that provide active help for an individual in such matters as education, employment, health, and social relationships. It includes many educational, casework, and counseling procedures. Classically, the relationship in guidance between client and professional has been an authoritarian one, that is, the guidance worker assumed the more active role in giving advice to the client. While an authoritarian relationship is often effective, particularly with clients who have difficulty with self-motivation, it is also dangerous in that the client may overvalue the capacities of the therapist and suspend his own reasoning and right to criticize. The client may have feelings of fear or awe toward the counselor. Should this occur, and doubt subsequently arise about the true capacities of the counselor, strong feelings of hostility and guilt will be aroused. Because health workers frequently seem to use an authoritarian kind of guidance in working with patients, they need to be fully aware of its hazards.

Psychotherapy is a form of treatment for emotional problems in which a trained person deliberately establishes a professional relationship with a patient with the objective of removing, retarding, or modifying existing symptoms, mediating disturbed patterns of behavior, and promoting positive personality growth and development. There are two main categories of psychotherapy: insight therapy and supportive therapy.

The purpose of insight therapy is to aid the patient to gain insight into his unconscious conflicts with efforts to achieve extensive alteration of his character structure and to further his personality growth through the development of his adaptive potentialities. Insight therapy may have one of two goals: a reeducative purpose or one that is reconstructive in nature. The objective of insight therapy with reeducative goals is to aid the patient to gain insight into his more conscious conflicts with deliberate efforts at readjustment, goal modification, and living up to existing creative potentialities, i.e. to free the patient so that he can become creative. There are many approaches to this type of insight therapy including relationship therapy, attitude therapy, interview psychotherapy, therapeutic counseling, casework therapy, and reeducative group therapy.

Insight therapy with reconstructive goals is that which attempts to reconstruct the personality of the patient. Psychoanalysis is one approach to this kind of therapy; analytically oriented psychotherapy is another. Psychoanalysis usually makes use of free association and is more concentrated in regard to time, the patient seeing the therapist five or even six times a week. Psychotherapy is usually less concentrated in time, perhaps two or three visits a week, and does not generally use free association. Other kinds of therapy which have reconstructive goals are hypnoanalysis, art therapy, analytic group therapy, and play therapy.

Play therapy provides a means for the child to give vent to his feelings, ideas, and fantasies that he can not ordinarily verbalize. This acting out in play of his fantasies and anxiety-producing life situations has a cathartic effect in alleviating tension. As his repressed drives are acted out in play, the child becomes desensitized to their influence. After successful play therapy the patient should no longer need to act out, that is, turn his inner urges and impulses into physical activity. Rather, he should then move to a stage at which he can verbalize them. The results of play therapy are based upon insights the child gains into his unconscious problems.

Insight therapy is not generally practiced by nurses since few have had the prerequisite training for it. An analyst should have experienced his own psychoanalysis plus a didactic analysis, that is, the analysis of a patient under the supervision of an already qualified psychoanalyst. If a person who has not undergone analysis himself attempts to use insight therapy, he tends to react in the therapy sessions in terms of his own needs and feelings without being aware of them.

Supportive psychotherapy, however, is one which nurses may use. The objective is to help the patient strengthen his existing defenses (unless they are very pathological) and to aid him in establishing new and better mechanisms for maintaining control or for reducing or removing detrimental external factors that act as sources of stress.

Newer Services. (8) The modalities described above are all still in use. However, in the 1960's, with the advent of community mental health centers, differing ways of delivering mental health services have been developed, especially for poverty groups. Some centers are spending considerable amounts of time and effort in trying to solve social problems. In this event, they may use group action to expedite change. Other centers include vocational counseling services at very basic levels; for example, they may consider how one gets and keeps a job.

In addition to the professional personnel who act in their usual roles, new types of personnel such as aides are being trained for use in community mental health centers, and the professional staff members are exploring new roles for themselves. The mental health problem now has two aspects; 1) how to develop more meaningful services; and 2) how to find better ways to deliver these services.

## Crisis Intervention

Gerald Caplan and Erich Lindemann have done much of the major writing about crisis and crisis intervention. (9) Their work is based upon the idea that a person in a state of crisis is in a state of disequilibrium. A crisis itself is an acute and often prolonged disturbance that may occur in an individual or a social group as a result of an emotional trauma. At times of crisis, more than at other times, it is possible to aid the person to utilize the psychic energy that is released and to mobilize his resources for maximum benefit to himself with minimum effort on the part of the therapist.

There are many different kinds of crises, some of the most common being the loss or threatened loss of a significant relationship through death, separation, or other cause; a change in role relationship; and adjustment to a new environment. Some kinds of crises occur in virtually everyone's life: birth, puberty, marriage, climacteric, and death, for example. Others occur in the lives of only a segment of the population; a serious illness during childhood, for instance.

Children must face various types of crises such as entering a new school, which requires adaptation to a new environment, or the birth of a sibling, which entails a change in his role relationships. To help children cope with these situations we may use some of the methods employed in crisis intervention.

The first step in crisis intervention is to evaluate or appraise the situation.

The individual himself must be involved in making this appraisal and taking a major role in identifying the problem. The healthy or positive parts of the situation need to be accentuated. The second step involves exploring the extent of the crisis and planning the intervention. Often it is necessary to assess the extent to which the crisis is due to the original problem and the extent that it has resulted from the person's attempt to deal with the problem. In coping with a death in the family, for example, various alterations in living patterns or in physical environment may occur.

While the original problem was the death of the family member, the attempts to cope with this loss frequently add to the complexity of the crisis. During this second phase of crisis intervention the strengths of the individual and available resources must be assessed and alternative solutions considered. The third step involves altering the balance of forces so that a positive resolution of the crisis may take place. This may be accomplished in various ways: by re-peopling the social space and filling the gap left by the loss of a significant other person, by redistributing the role relationships, by developing alternative means for interpersonal need satisfaction, by developing new skills and interests, or by redefining the predicament. Through these and other methods, the crisis will, hopefully, be resolved and the final step, anticipatory planning, can take place.

## Consultation

Consultation was defined as an experience in human relations through a sharing of knowledge between two people. Gerald Caplan refers to mental health consultation as an interaction process taking place between two persons, consultant and consultee. (10) Industry, business, management, professional and educational enterprises are examples of the many groups that depend upon the help of consultants of various kinds.

The position of consultant in any of these groups is unique. He is not part of the formal structure of the organization. He does not supervise or manage; he is not responsible for judging performance or direction of personnel. He does need, however, an intimate knowledge of the field in which he is consultant and of the purposes, structure, and "subculture" of the particular institution or organization he seeks to assist. To be most effective, he must be relatively free from restraints in collecting this information and he must maintain a channel of communication between himself and the consultee. The ultimate purpose of consultation is to help the consultee use his own knowledge and skills to deal with the situation.

The consultee may seek the services of the consultant for various reasons. He may feel the need of consultation himself, it may be suggested to him, or he may be given little choice in the matter. Caplan feels that the response is best when the invitation is based on the consultee's recognized need of the consulting services. He states:

> The greater the consultee's anxiety and emotional disturbance regarding the problem, and the more intense his feelings of urgency, the more auspicious the situation is for consultation contact. In other words, the more intense the crisis, the more powerful the forces involved, the better the chance for satisfactory consultation. (11)

The first step in consultation is definition of the problem. Necessary background data would include information about the subject to be discussed and the structure within which the discussion will take place. The problem must then be considered from two points of view: that of the consultee and that of the consultant. Influencing the consultee's view of the problem are his expectations, hopes, and attitudes toward consultation. It would be significant to know who invited the consultant and whether the consultee actually wants help with solution of a problem, desires support and reassurance that he is already handling the problem well, or resents any interference whatsoever in the situation. He may feel threatened by consultation or perhaps lukewarm about the whole idea.

While the consultant's view of the problem is likely to be more objective, his own aims, goals, and attitudes must be considered. Caplan makes a very important point in regard to the latter:

> The consultation process will, almost inevitably, involve an attack on some of the defenses of the consultee and of his social system, but there is no way of telling in advance which defenses will be dealt with in this way, and in many cases certain defenses will have to be strengthened rather than weakened. It is usually the consultant's own insecurity, his fear that he may be manipulated too far from his defined role, that is responsible for mistakes in the area. (12)

The consultant needs to be aware of his own feelings and approach. All his interviewing skills come into play. He must give the consultee an opportunity to deal with the problem and then build upon the strength in the consultee's approach. He must attempt to convey to the consultee a sense of respect for him, a feeling of acceptance, and an understanding attitude. Reassurance, however, especially during the early stages of the contact, may hinder rather than help the consultation process. If the consultant attempts to reassure the consultee with an "everything will be all right" approach, the felt need may be reduced and the consultee may break contact. On the other hand, the consultee may feel frustrated and angry that the consultant has apparently not understood the situation, since it is evident that "everything will not be all right." The consultant needs to avoid "letting all the air out of the balloon of anxiety" and allow the consultee the privilege of doing this by working through a solution to the problem.

After the solution of the immediate problem, channels of communication should be maintained. Regular systematic contacts are preferable to occasional or crisis consultation. The consultant-consultee relationship can be sustained for dealing with other problems which arise as long as it is not carried to the point of dependency. Finally, progress must be appraised both in regard to the original problem and in respect to the consultee's developing ability to assume appropriate responsibility for subsequent problems that may arise.

## Discussions With the Psychiatrist

As in the first workshop, a psychiatrist who specialized in work with children participated in discussions. On some occasions he was asked to formally present material which the students felt they needed to know; information about various medications used in the treatment of children with emotional problems, for example. More often, however, he led discussions about topics that the nurses raised in class and that were based on their own school nursing experiences. The paragraphs which follow are summaries of a few of these discussions.

The hyperkinetic child has a short attention span and engages in almost constant motor activity. The syndrome is often associated with mental retardation or with a history of perinatal complications, prematurity, or encephalitis. Occasionally, the condition seems to stem from a developmental lag of unknown etiology. The hyperkinetic child appears to be stimulus-bound; he is unable to screen environmental stimuli to select those that are important or relevant but reacts to all of them. Some children of normal or above average intelligence seem to "grow out of" the problem at puberty. Treatment with Dexedrine, sometimes very large doses, has been remarkably effective in many instances. The theoretical explanation of the drug's action is that it increases the energy level in the brain so that the child's hierarchical sorting mechanism functions more effectively, thus improving his ability to block out extraneous stimuli.

The obese child presents a very particular problem to the nurse in the school. The factors contributing to obesity are numerous. Frequently it is a symptom of a complex personality problem. For this reason, it is wise for the nurse to proceed with caution when she attempts to help a child reduce his weight. One general rule that might be followed is to help if he wants to be helped but to avoid pressure of any kind if it becomes evident that weight reduction is too difficult a task for him. The nurse can provide information that helps to give the child an intellectual understanding of his nutritional requirements, and she may provide support and encouragement to the youngster who is attempting to lose weight. Occasionally she may be instrumental in helping to organize small groups of pupils who have this goal in mind and who can share experiences and offer mutual support. Of prime importance in working with an obese child, however, is conveying an acceptance of him as he is. Through a warm relationship with him, the nurse can help him to build up his self-esteem, to develop his capacities in all areas, to gain an understanding of his problem, and to seek professional aid in solving it.

The handicapped child. The school nurse is faced with several problems when working with a handicapped child. Some of these relate to helping the child and his parents toward an acceptance of the condition and a comprehension of what can be realistically expected for the child. She shares these tasks with other professional health personnel who are working with the family. Her special work, however, involves assisting other children and the school staff to understand the handicapped child.

Children may have many fears about a handicapping condition. Some are afraid the same thing may happen to them; others react with fear to any child who is markedly different from themselves. They need an opportunity to talk about the handicap, to ask questions. Sometimes the nurse or teacher can initiate discussion by asking what they think it would be like to have a particular handicap, what they think others would think about them, or how they think the handicap came about.

Teachers, too, may have some of these feelings about a handicapped child. In addition, since they are responsible for the children within their classrooms, they may fear not knowing what to do if the handicapped child needs help. For example, a teacher may dread the thoughtof being with a child having an epileptic seizure for fear the child might die or be seriously injured while she stands by, helpless, not knowing what to do. She may find it difficult, too, to keep in mindthe very special educational needs of a child with a visual or auditory handicap while attempting to teach 25 other children as well. The nurse can help here in providing the information and reassurance needed by the teacher and by supporting her efforts to work with the handicapped child and his parents.

The nurse in the school also has the special task of discussing with the handicapped child any school difficulties he may be having, and perhaps suggesting the school staff adjustments or adaptations in his educational program. If she can establish a warm, accepting relationship with the child, he will feel more at ease sharing his concerns with her and expressing his feelings about his handicap and the reactions of others to him. Through her willingness to honestly discuss his handicap with him the nurse can convey an acceptance of his difficulty and an acceptance of him as a person.

The child and death. During the first workshop, several participants had worked with children in the hospital who faced serious surgery or a terminal illness. They had been concerned about helping these children cope with their fear of death and were seeking ways of encouraging them to express their feelings. Others had encountered situations in their school nursing practice in which a member of a child's family, a fellow pupil, or a pet had died. The film "Afraid of School" which they viewed during the first workshop also raised this issue. Throughout both workshops, then, the topic of death and how the child views it and copes with it came up. The most extensive discussion, however, occurred during the sessions with the psychiatrist in the second workshop.

The child's concept of death may be hazy. Often he has inadequate information upon which to base his assumptions since adults are reluctant to talk to children about the subject. From television, and from his own magical thinking, he may think that death is only temporary, that the person who has died will return as the actor who plays the dead outlaw returns the following week on another program. Adults have a responsibility to help children in their attempts to grasp the concept of death. Sometimes the school can help in this. When a classroom pet dies, for example, explanations and answers to children's questions need to be freely given. If they express a wish to stage a full burial ceremony, this too may be useful in helping them understand the phenomenon of death and the customs surrounding it. It allows them to experiment with their own feelings related to death. For the same reason, parents can be encouraged to involve their children to at least a limited extent in family activities when a member of the extended family dies in order that they may gradually learn to cope with death before they must deal with it in the immediate family.

The death of a child's parent can be viewed as a real psychiatric emergency. Probably any child who experiences this can profit from professional attention during this crisis. Studies have indicated that the suicide rate among individuals who have lost one parent during childhood is triple the rate in the general population; the rate among those who have lost both parents is nine times that of the general population. Psychiatrists have found that often aspects of an individual's personality development remain fixated at the stage at which they were when the death of a parent occurred.

A young child, under the age of 11 or so, does not go through the usual mourning process which is seen in adults. This process, described in Freud's classic paper "Mourning and Melancholia," consists of three phases. The first phase is an immediate denial of the reality of the death of a loved one. This normally lasts for a few minutes or a few hours. The second phase is profound sorrow and the temporary loss of the ability to cope, a true crisis situation. Finally, over a period of weeks and months, a depression occurs. The individual thinks about the person who has died, perhaps dreams about him. This period may last as long as a year while the individual "pulls back" into himself the emotional involvement he had with the dead person. After this occurs he is able to reinvest these feelings, the emotional charge, in someone else. Freud called this the work of mourning, a sort of decathexis. It differs from melancholia in which the lost person is so much identified with the self that there is no separation, no real mourning possible.

There is a theory that during early adolescence, an individual goes through a primary period of mourning, the loss at this [illegible] being the loss of the ideal parent image. After this happens, the adolescent is able to experience the adult mourning process.

A child, however, may experience the death of a parent as a profound threat to his security. In the normal egocentrism of childhood, his first question is, "Who's going to take care of me?" These feelings of insecurity are ordinarily so overwhelming to him that denial takes place and immediately after his parent's death he feels nothing. Older children may wonder about this and feel guilty about it. They observe adults' reactions to the death and think they ought to feel grief as the adults do. After a period of time, however, a month or perhaps several months, the child often exhibits aggressive behavior. He feels anger at having lost a parent and the anger is often directed toward the surviving parent. In the child's view, the omnipotent surviving parent allowed or caused the death of the other parent.

Death of a sibling is ordinarily not as overwhelming to a child as the death of a parent although in this instance, too, he may have the problem of dealing with guilt feelings. To a child, wishing or thinking about something may cause it to happen. Because he has felt hostility at one time or another toward his sibling and perhaps wished him out of existence, he feels that he is responsible for the sibling's death. This is related to the feelings of omnipotence that he experienced as an infant.

As to suggestions for nursing actions that can aid the child in coping with a death in his family, the psychiatrist noted that first, it might be helpful to the child to be reassured about his absence of grief feelings. He also suggested various ways in which the child can be encouraged to express his questions and thoughts. Such questions as "What do you think happens when a person dies?" or "Why do you think it happened?" may elicit the child's perceptions of death. Reassurance or added information might be appropriate depending on the answers to these questions. It is of prime importance that the child have an opportunity to talk with an accepting adult who can share his concerns and will answer his questions. The nurse might be helpful in aiding the child to put into words some of his fears, perhaps by commenting that people have many different ideas about death and that she is interested in learning about his. This kind of approach encourages discussion and questions and might be useful in helping children in general deal with the concept of death. The nurse might also aid the family in developing an understanding of the child's reaction to death and suggest ways in which they might help him deal with this crisis, including referral to a mental health facility if such is available.

Anorexia nervosa. During the field experience some of the workshop participants had occasion to observe a patient with anorexia nervosa. The psychiatrist explained that this is a severe, often fatal disease that occurs in adolescence, more often in girls than boys. Its onset may be insidious. Sometimes a girl ostensibly goes on a diet and just never goes off it with the result that symptoms of severe malnutrition appear - amenorrhea, diminution of secondary sex characteristics, and cachexia. The adolescent is then hospitalized and gavage or intravenous feedings instituted. Anorexia nervosa is often thought to be part of a psychotic process. Psychiatric treatment for this condition varies, however. Some psychiatrists view it as being symptomatic of severe depression and treat it as such, possibly using electroconvulsive therapy. Others see it as being associated with the child's earliest emotional feelings about feeding and use intensive psychoanalytic therapy over a period of years.

Glue sniffing. Several workshop participants had had experience with children who were suspected or known to be experimenting with glue sniffing. Questions arose as to the effect of this practice. The psychiatrist noted that glue contains butyl alcohol, a potent fat solvent. It is possible for users to "get high" by inhalation of the alcohol. The habituating practice, if carried on over a long period of time, is harmful to both the liver and nervous system. Users may develop symptoms of brain damage which probably results from the direct action of the butyl alcohol on the lipids in the nervous system. Some fatalities have also been reported.

## The Role of the School Nurse in Mental Health

Several class sessions were devoted to discussing the application of the ideas and theories presented in the workshop to nursing practice. Often participants described situations they had encountered in their work in schools and speculated about the effects of actions that they had taken or suggested alternative modes of behavior. From these discussions, the contribution of the nurse to the mental health of pupils and their families was clarified.

First, her responsibility in primary prevention was identified as consisting of two aspects: 1) helping children and their families cope with normal developmental and situational crises in order to prevent mental illness, and 2) promoting a mentally healthy school environment that is free from unnecessary stress and consistent with the mental health needs of all school personnel.

Secondly, in the area of treatment, her major responsibilities were identified as consisting of: 1) assisting with early identification and referral of children who appear to have mental health difficulties, and 2) providing general support for the child during treatment and cooperation with the active treatment agency.

In order to effectively carry out her responsibilities in the area of mental health in the school, the nurse must develop skills in three primary areas: 1) observation; 2) counseling; and 3) analysis of her own behavior. In the area of observation, skills which would aid the nurse in identifying crises and sources of stress in children's lives are particularly important. Knowledge of normal growth and development provides a background against which she may view each child as he progresses within his unique developmental pattern.

In the second area, counseling, the nurse must develop skill in non-evaluative listening, in establishing an accepting climate for discussion of any concerns the child might wish to express, and in aiding the child in his exploration of a problem. An understanding of child psychology and of communication theory form a basis upon which the nurse develops her own particular style of conversation with children.

Self-understanding is perhaps one of the most difficult kinds of knowledge to acquire. The nurse who has developed some skill in analyzing her own behavior and who systematically applies this skill in practice, however, will find that such analysis will assist her in her efforts to deepen her insight and to assess the effects of her verbal and nonverbal behavior on others. As she increases her sensitivity to the responses of others to her and her communication, and in turn becomes more open to their messages, she is able to enhance the interactions between herself and her patients.

Educational Films

"Aggressive Child" (13) is a film that relates the story of Philip, a 6-year-old who seems to be constantly fighting at home and at school. A child psychiatrist helps Philip act out his fears and feelings in play therapy as his mother receives conseling from another psychiatrist. It is revealed that much of Philip's fighting is an expression of the fear he feels at his success in playing one parent against the other. Faced with inconsistencies in parental behavior and a frightening sense of his power in manipulating his parents, Philip asks for help through disruptive behavior. After several months of treatment, Philip learns better ways of expressing his feelings and his parents find that he responds to the increased consistency and harmony in their behavior toward him.

The film "Bright Boy, Bad Scholar" (14) focuses on those children with average or above average intelligence who have learning problems. Various children introduced in the film have had difficulty learning to read, write, organize information, or handle abstract concepts except through special programs designed to meet their individual needs. Dr. Sam Rabinovitch of the Montreal Children's Hospital learning Clinic demonstrates some of the methods used to help these children. The film stresses the need for early recognition of these children and help for them to circumvent recurrent failure in school and its emotional implications.

Special photographic effects help make "The World of Schizophrenia" (15) a fascinating film. It attempts to portray how a schizophrenic young man views the world around him. One "sees" with him his hallucinations and distorted perceptions. One feels with him the confusion and fear that accompany his delusions. This film was particularly useful in the workshop because it helped the participants gain insight into the terrifying distorted experience of a psychotic individual. After "seeing" the world of the schizophrenic through his eyes, they felt better able to understand some of the factors contributing to disturbed behavior.

"In and Out of Psychosis" (16) depicts a series of family interviews with a psychiatrist. It is similar in nature to "The Enemy In Myself" which had been utilized in the first workshop. In this film, however, the sequence revolves around a family consisting of a mother, father, and a teenage daughter who is manifesting hallucinatory behavior and other signs of schizophrenia. As the family relationships are explored, some of the factors involved in the girl's illness come to light. Particularly significant are the relationships between father and daughter and between mother and grandmother. As some of the hidden conflicts are resolved, the daughter's bizarre behavior decreases and her retreat from reality is somewhat reversed.

## PART III

### Field Experience

The original plan for participants' field experience in the second workshop called for each nurse to spend a considerable amount of time with an emotionally disturbed child as she had with a normal hospitalized child during the first workshop. Difficulty arose, however, in locating an agency that was able to provide the type of field experience envisioned in the plan. Numbers presented a problem, for 20 children whose condition permitted this kind of visiting were needed to provide the one-to-one contact that was desired. In addition, the cooperating institution had to be within a reasonable commuting distance from the college where the workshop was being held. Personnel in one agency which was approached felt that it was impossible to accommodate nurses for this kind of experience at that particular time.

With the research nature of the institution in mind, a request was made to

Psychiatric Institute, a New York State hospital that has affiliative ties with Columbia-Presbyterian Medical Center. (For a description of Psychiatric Institute, see chapter I, p. .) The Institute expressed interest in providing field experience for workshop participants but, because of the low number of patients on their children's unit, it would be impossible to arrange the one-to-one ratio between participants and children. After discussion it was decided to modify the planned field experience and enlist Psychiatric Institute as a field agency.

The field experience for the participants in the first advanced workshop consisted of three afternoon observation periods of one hour each followed by discussion with workshop and hospital staff about the children. During their time with the children, they accompanied the youngsters as they participated in their usual programs: shopping trips, visits to the park, play periods in the gymnasium, and indoor recreational activities. In addition, a half day was spent at the Institute in meetings with various staff members who explained the philosophy and work of the institution, and in observing a case conference.

The next year, somewhat different arrangements had to be made because of the smaller number of children in the unit at Psychiatric Institute. Participants spent one full day there, dividing their time between lectures, meetings with the staff, and observation of the children. In this experience, the group was subdivided to avoid overwhelming the children with large numbers of adult visitors at any one time. The following day, participants again had a one-hour observation period in the field agency. For the third and fourth groups, this hour was eliminated as the census again was very low.

In connection with their field experience at Psychiatric Institute, participants in the second, third, and fourth workshops used an observation guide that had been developed at the end of Workshop I (see Appendix, p. 200, for a sample of the observation guide). The purpose of this guide was to focus the nurses' attention on particular aspects of the child's appearance and behavior during the observation period: his physical appearance with respect to stature, complexion, posture, grooming, visible defects, and coordination; his behavior; his verbal activity with respect to tone of voice and language; his nonverbal means of communication; and his relationships with adults and peers. Following the observation period, participants had the opportunity to talk about what they had seen with staff members who could relate some of the children's background and experiences. Observations also provided one source for the topics raised in discussions with the psychiatrist in regular workshop sessions.

### Other Learning Activities Utilized in the Advanced Workshops

According to the original workshop plan, each participant was to present her own process recording of an interaction she had with a school child during the year between the first and second workshops. The rest of the group would then have the opportunity to comment and raise questions. As the time for the sharing of process recordings approached, however, it became evident that the nurses were becoming increasingly anxious about this presentation. After this was recognized and discussed with the first group of participants, the teaching staff decided to abolish this portion of the plan and confine the analysis of each participant's process recording to a conference between her and two workshop instructors. In addition, one case study and examples of the nurse's process recordings of interactions with this child were analyzed in class.

In the second, third, and fourth workshops, dittoed sheets containing excerpts from various process recordings were used. (See pp. 201-03 in Appendix for sample sheet.) Each participant was asked to state whether she considered the nurse's response to the child satisfactory or unsatisfactory and then comment on her answer. If the student responded "No," she was to give what she considered to be a better answer and a brief statement of her reason; if she responded "Yes," she was to state why she considered the nurse's answer to be satisfactory. Each of these examples was later discussed by the entire group.

A third type of learning activity utilized in the third and fourth workshops was the small group discussion. This grew out of discussions among the first two groups about exchange of information between a mental health agency and the school. The problem was presented as follows:

> There is a child in the school in which you are employed who has been manifesting disturbed behavior. Through your school physician you received a diagnosis of schizophrenia following a referral for psychiatric consultation. This diagnosis alone cannot be helpful to you or the other members of the school staff. In order to improve services to children please:
>
> (1) List the points you would include in a letter designed to obtain the information you really want.
>
> (2) State the ways in which this information might be used.

Several points came out in the small group discussions and in the review of these discussions in the entire group. In regard to the first question, participants listed the following points which they might include in such a letter: 1) a statement of how the school expected to use the information the psychiatrist provided; 2) a request for information relating to the child's medications and his reactions to them; 3) suggestions regarding his management in the classroom, and guidelines for behavior of the staff toward him; 4) a proposal for a conference which would include the psychiatrist and selected members of the school staff; and 5) a request for suggestions regarding the school's contacts with the child's family.

In discussing the second aspect of the problem, participants felt that a conference with those members of the school staff who were directly involved with the child would be an appropriate means of sharing the psychiatrist's information. Only information that would be directly useful to school staff would be shared. Information regarding specific diagnosis and details of psychiatric treatment would not be appropriate to give out at this kind of conference.

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9. For examples, see: Gerald Caplan, An Approach to Community Mental Health. New York: Grune and Stratton, Inc., 1961; Gerald Caplan, Principles of Preventive Psychiatry. New York: Basic Books, Inc., 1964; Donald C. Klein and Erich Lindemann, "Preventive Intervention in Individual and Family Crisis Situations." In Prevention of Mental Disorders in Children, ed. by Gerald Caplan. New York: Basic Books, Inc., 1961.

10. Gerald Caplan. Concepts of Mental Health and Consultation. Washington: United States Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau Publication No. 373, 1959, p. 187.

11. Ibid., p. 121.

12. Ibid., p. 124.

13. Robert Anderson. "The Agressive Child." Produced by Robert Anderson. Available through the National Association for Mental Health Film Library, 267 West 25th Street, New York, New York 10001.

14. Robert Anderson. "Bright Boy, Bad Scholar." Produced by Robert Anderson. Available through the National Association for Mental Health Film Library, 267 West 25th Street, New York, New York 10001

15. "The World of Schizophrenia." Pharmaceutical Division, Sandoz Inc., Available through Association Films, 600 Grand Avenue, Ridgefield, New Jersey.

16. "In and Out of Psychosis." Available through the Family Institute, 149 East 78th Street, New York, New York 10021.

## Chapter V

## EVALUATION OF THE WORKSHOPS

### Evaluation by Participants

On the last day of the first workshop, participants were asked to complete an open-ended evaluation instrument. Data from these questionnaires collected from the first two groups were used to construct a 60-item checklist which was then utilized as the primary evaluating tool for the workshops, (see Appendix, pp. 190-94, for questionnaire). Participants in all four groups were asked to respond to this questionnaire although by this time those in the first workshop had already participated in their second one. Because of the time limits of this study, it was decided that the optimum time to ask participants to respond to this questionnaire was during the spring following the first workshop. It was felt that by that time the participants would have had the opportunity to integrate any knowledge, skills, and understanding they had acquired in the workshop and apply them in practice. This timing of the questionnaire also ensured that the maximum number of responses could be obtained from the 80 participants and also, the opinions of Group IV, whose second workshop was scheduled for June, 1969, concurrent with the submission of this final report, could be included in the analysis.

Participants were asked to indicate the degree of influence they felt the workshop had had on their knowledge, understanding, and abilities in mental health and school nursing in each of 60 areas. Alternatives offered in "degree of influence" were "great," "some," "little," and "none." Space was provided for comments regarding each item. Seventy-four questionnaires were returned; this represented 92.5 percent of the entire group of 80. The data were analyzed in two dimensions: the number of items or areas in which a majority (i.e., 37 or more) of the respondents felt the workshop had had great, some, little or no influence; and the number of areas in which a plurality of respondents felt the workshop had had some degree of influence. When an item was checked as an area upon which the workshop influence was "great" by more participants than the number who checked "some," "little," or "none," the item was included in the list of those upon whom the influence of the workshop was "great" as indicated by a plurality of respondents (see Appendix, pp. 175-79 for frequency distribution). The analysis of the responses follows:

A majority of the workshop participants indicated that the workshop had had a "great" degree of influence on their knowledge, understanding, and abilities in mental health and school nursing in each of the following areas:

Item 46. Desire to pursue further study in mental health and other related areas in school nursing (81%).

Item 60. Insight into own attitude and behavior and its effects on children and others (72%).

Item 32. Ability to study and analyze own feelings and behavior toward others (70%).

Item 38. Understanding of roles and functions of the school nurse in mental health area (62%).

Item 8. Ability to assess total needs of children (61%).

Item 16. Knowledge of communication theory, e.g., verbal and nonverbal modes (58%).

Item 13. Interest in helping children and others with mental health problems (57%).

Item 21. Awareness of attitudes of children, parents and others toward me (57%).

Item 39. Reading or using reference material on mental health and psychiatry (57%).

Item 5. Ability to interview children and others (54%).

Item 37. Desire to work with school personnel on mental health needs of children (54%).

Item 9. Willingness to discuss emotional problems with parents, school staff, etc. (53%).

Item 35. More self-confidence in dealing with emotional problems (51%).

Item 44. Spending time with emotionally upset children and others (51%).

Item 52. Ability to function as a team member with others on problems of children (51%).

A plurality of respondents rated the workshop as having had a "great" degree of influence in a total of 22 areas. In addition to the 15 listed above, the following areas were also mentioned:

Item 11. Understanding of multiple factors that influence mental health and behavior (49%).

Item 33. Personal growth and life (49%).

Item 34. Objectivity in approach to others (49%).

Item 50. Relationships with various personnel in the school (49%).

Item 51. Understanding of ways that school nurse can promote positive mental health in the school (47%).

Item 12. Attitudes or feelings toward children and parents (45%).

A majority of respondents rated the workshop as having had "some" degree of influence in a total of 16 areas. A plurality rated it as having had "some" degree of influence in a total of 37 areas. In only one area, "awareness of community resources," did a plurality of the respondents indicate that the workshop had had "little" influence. There was no area in which a plurality of the workshop participants had checked "none" as the degree of influence they felt the workshop had had.

Toward the end of the second workshop, the nurses in the first three groups were asked to respond to five open-ended questions in a "progress report." (See

Appendix, p. 195-97 for sample form). Several of these questions seemed to elicit information which was similar in nature to that revealed by the 60-item evaluation checklist and therefore did not substantially contribute to evaluation of the workshops. One of the five questions, however, requested that the participants identify "unmet needs" in the area of school mental health that they were experiencing in their work situations. Responses appeared to fall into nine general areas (Table 18, p. 180).

One of the most frequently mentioned areas was the need for increased mental health facilities within the community. Fifteen out of the 44 nurses who responded indicated this as an unmet need in their particular situations. Several others felt that better utilization of community mental health facilities and better communication between these agencies and the school were needed.

An equally large number (N=15) of the nurses felt that there was a need for the entire school staff to have better preparation and inservice education in order to increase their understanding and skills relating to mental health. A third unmet need was that of better communication and cooperative relationships among school staff in matters relating to mental health. Fourteen nurses listed this as a problem in their school districts. One wrote:

> In some of my schools we do not use the team approach to problems. Each person has his own job and there is very little contact among the different people working with children.

One-fourth of the respondents (N=11) suggested that the school nurses themselves needed increased knowledge, self-understanding, and evaluative skills. Some felt that cooperation among the nursing staff members in a revision of present methods was indicated. Although the numbers of professional mental health workers in the schools have been increasing steadily, nine nurses listed as critical the need for increased mental health personnel within the school. Specifically, they felt that more psychologists should be employed by their schools and several mentioned the desirability of at least part-time service of a consulting psychiatrist.

Specific practical considerations composed another area of concern. Six nurses felt the need for more time to work with individuals and groups as well as better facilities to ensure privacy and confidentiality during these interviews. Four nurses indicated the need for earlier identification of children who might have emotional difficulties. One respondent was especially concerned about those children whose need for help was not communicated to staff because their behavior was not of a "disturbing" nature. The withdrawn, underachieving students, she felt, were sometimes overlooked. Three nurses indicated that there was a particular need in their work situations for comprehensive, long-range planning and follow-up for disturbed children. One nurse in a junior high school described the situation in this way:

> The problem students' needs are not met. Their behavior is tolerated from day to day. There are no "in depth" plans; there is some superficial counseling but for the most part we wait until students are 16 or go to reform school. A few of those who are eligible are steered toward rehabilitation; some are sent on to high school. We had about 66 students under psychiatric care last year.

Finally, four nurses mentioned the need to reduce the stress within the school environment itself, the need to promote an atmosphere conducive to the mental health of both staff and students. Various other areas were mentioned by one or two of the students but the nine described here were the most consistently mentioned themes.

The final question on the progress report form asked what additional information the nurses felt would be needed to help them work more competently in the area of school mental health (see Table 19, p. 181). Forty-one of the 44 respondents indicated that some additional information would be desirable. The largest number (N=11) stated that further educational experiences of the kind offered in the workshops would be beneficial. They felt that continuing exploration to increase the depth and breadth of knowledge in the field of mental health would be useful. Several mentioned the desirability of frequent up-dating in the areas of literature and research in mental health. Other respondents listed specific topics or content areas which they felt would be of assistance. Eight mentioned knowledge and practice in counseling; seven listed child psychology and psychiatry. Seven expressed the need of additional knowledge and guidelines related to fostering positive interpersonal relationships and cooperative attitudes among school administrative staff, faculty, special service personnel, and community workers. One, for example, was interested in additional knowledge that would aid her in promoting a team approach to a pupil's problem. Closely related to this was another area of concern listed by five nurses who felt that additional knowledge regarding group processes and techniques of working productively with groups of students would be desirable. Four nurses indicated that they desired further knowledge which would aid them in self-understanding. An additional four suggested that further exploration and clarification of the role and function of the school nurse in mental health would be helpful. Areas that were mentioned by one or two individuals were: increased knowledge about exceptional children, particularly those with learning disabilities; information and guidelines in the initiation and promotion of inservice programs for school staff; and knowledge about community planning.

Participants not only commented positively on various evaluation forms, but they also wrote letters to the workshop instructors and the project director that revealed a positive response to the workshops.

> I sincerely believe that this workshop has been a great step in my life, personal as well as professional.
>
> Very few days go by that some aspects of the workshops do not come to mind and prove helpful in interpreting or solving some problem.
>
> In reviewing what took place at both workshops using the recordings, I feel I have a much better insight of what my reactions, conversation, and information obtained, and how they enhanced my ability to see situations from the students' point of view rather than my own.
>
> Just a short letter to tell you how much your workshop in mental health has helped me and in doing so has helped many children and parents because of my awakened sensitivity.
>
> Specifically I would like to briefly tell you about three children whom I have seen recently. One was a 10-year-old boy complaining about a headache and in tears all the time he was talking. It was report card day and his turned out not to be so good. Support and listening were needed and there are plans for more talking to each other with teacher and parent involvement.
>
> A 6-year-old girl came into the Health Office sobbing that her stomach hurt. I made a visit to the classroom teacher to see if she could shed some light on the extreme sobbing, but she couldn't. The mother was not at home, but a close friend said that the mother had been going to the hospital to visit a critically ill baby sister and had not been home very much in the last week. After holding the child on my lap and talking to her about her mother and sister, the sobbing stopped, and in about half an hour the stomach ache stopped and she went back to class.
>
> A 9-year-old boy has been coming to my office regularly since his mother died very suddenly two months ago. His complaints are many, but primarily headaches and stomach aches. Conferences with teachers, a friend of the family, and his father showed that the family needs some psychological counseling to help them through their grieving

> period. The father is extremely grateful for the support his son is receiving in school and the help he will be receiving with some of his worry.
>
> I thought you might like to share some of these experiences with me. I can do a better job because of the workshop. Thank you.

In addition to an effect on the subsequent practice of participants, the workshop had other outcomes. One nurse stated that participation in the workshops "directly influenced my pursuit of graduate study." Actually, six participants indicated that the workshops influenced their decisions to seek advanced education.

Finally, two of the workshop participants were instrumental in initiating planning for a similar mental health workshop for school nurses in their state. A proposal for this was submitted to the National Institutes of Mental Health and financial support was obtained. Similar workshops will be held in the state of Alaska with the first of the series beginning during 1969.

### Supervisors' Evaluation of Participants' Performance

The immediate principals or supervisors of the workshop participants were asked to submit their views on the influence of the workshop upon the nurses' work with children (see Appendix, p.     for sample of the letter requesting this information).

A total of 74 letters were received evaluating 49 of the workshop participants. (Some nurses had more than one immediate supervisor; four was the maximum number of letters submitted for any one nurse.) A simplified content analysis was performed to determine the kinds of changes in behavior observed in the workshop participants.

Virtually all supervisors made favorable comments in respect to the overall performance of the workshop participants in the school situation. There were no negative or unfavorable remarks in this area. While a few stated the difficulty of identifying definite changes in behavior which could be linked directly to participation in the workshop, most held the view that the experience had facilitated improvement in the nurses' understandings, attitudes, and practice related to mental health. One stated: "The school year just past has been one of [the nurse's] best years and I am sure the assurance and help she gained from the workshop substantially contributed to this situation." Another commented: "She was a good nurse before she attended the workshop, but has demonstrated she is a better nurse by having done so." A principal wrote "I am very pleased with the workshop and with the impact that [the nurse's] attendance has had on the high school."

Several supervisors pointed out that the difficulty in assessing change arose in part from the excellence of the nurses' performance prior to the workshop as well as at present. One enthusiastically stated: "When a nurse-teacher such as [the nurse] is involved in a course such as completed at your college, the outcome for a 'great' teacher will be less than that of a 'poor' one. My point is that ... it is difficult to improve her already existing terrific program." Eleven supervisors reported that they could not assess change in behavior since their working relationships with the nurses were initiated after the first mental health workshop was held.

The data contained in the comments made by the nurses' immediate supervisors regarding their perceptions of changes in the nurses' overall performance following the nurses' participation in the workshops were grouped into three general categories: acquired understandings, attitudes, and observed practice (see Table 20 on p. 182 of the Appendix).

Thirty-seven of the supervisors of the workshop participants felt that the nurse had gained in the area of understanding, particularly in two respects: insight and understanding of pupils, and awareness of mental health problems. A total of 20 specifically mentioned the former: "... it seems to me that the experience was valuable insofar as it helped her to sharpen her insights and to perhaps determine, as a result of interaction with others, more effective approaches that might be taken in the field of school nursing." "I am happy to report that she seems to have a deeper insight into children's problems and has improved rapport with children and adults." "We feel that [the nurse] during this past year has developed a keener awareness of the interaction that the total environment has on the growth and development of children. [She] has also developed a deeper understanding of the total needs of children and especially the impact of stressful situations at particular periods of growth. ..."

Fifteen supervisors mentioned increased awareness of mental health problems. A superintendent of schools wrote: "She shows better identification of pupils who are emotionally and socially disturbed. ..." A principal commented: "I have observed that [the nurse] has been more perceptive in her ability to sense and diagnose problems before they become acute than previously . . . ." Improved understanding of parents' attitudes and concerns was also reported.

Acquired attitudes. In the area of change in attitudes, six supervisors specifically identified increased self-confidence as an outcome of the workshop. "She has exhibited a more comfortable, secure view of herself during this year." "Perhaps the most obvious outcome of the workshop last summer was that of giving

/the nurse/ the confidence that she was on the 'right track'." Six supervisors reported changes in attitudes toward others: increased tolerance, acceptance, or patience. For example, one stated: "She has demonstrated more patience in dealing with children and parents . . . ." Another wrote: "As a result she is more understanding and patient with students involved with emotional problems." One reported: "... those of us who worked regularly with /the nurse/ noticed a great improvement in her attitude toward her work with young people this year." Three supervisors felt that workshop participants evidenced greater enthusiasm and interest in mental health projects. These are in addition to the large number who described specific projects, such as in inservice education, in which the nurses became involved. A more cooperative attitude was noticed by two supervisors. Three specifically mentioned increased objectivity on the part of the nurse when working with children; one commented: "There also seems to be an increased ability to relate objectively to boys and girls while formerly the tendency was to become attached, overly involved emotionally . . . ." Another wrote: "It would seem that she has developed a more objective view of the individual's total personality in relation to areas other than, or in addition to, the physical aspects." Several supervisors reported other outcomes which fall generally in the category of attitudes. Two stated that workshop participants had evidenced interest in further education as a result of the workshop. A third felt that the nurse's interest in professional nursing organizations was greatly stimulated.

Observed practice. The greatest number of comments made by the participants' supervisors related to the practice area. A total of 88 specific comments were made. Of these the largest number, 31, related to work with individual participants and staff members. A few samples of the comments follow: "[The nurse] has received much assistance from the interpersonal and communication theory in the interviewing and counseling of staff and patients." "[Her] seminar on mental health last summer has been put to good use in her skilled handling of a recent case of school phobia." "... I would say that [the nurse] has made a more intensive effort to improve mental health on an individualized basis. She has worked with some of our more severe attendance problems and changed their attitude toward school for the better." "Since we have a number of students attending the high school who are residents of the . . . State Hospital this course has helped in many ways to ease the transition from an institutional setting to the normal classroom situation."

Eleven comments related to work with pupils' parents. One supervisor wrote: "She has evidenced a deeper appreciation of parents' attitudes and concerns in that she is conscious of how the parent views her as an individual and as a member of the school staff. This, she has recognized, has facilitated improved interaction and thus, better results in that which she is attempting to achieve."

About one-third of the letters, 23 in all, mentioned improved collaboration with co-professionals within the school. "From my observation, [the nurse] is now in a better position to interpret pupils' problems to teachers and to assist teachers in dealing with them in the classroom setting." "She has a better line of communication between herself and teachers as well as students." "[The nurse] has been a great asset on our Pupil Personnel Committee." "She has promoted many innovations which have been a help to the student body. Since completion of the workshop she has initiated a guidance committee which involves classroom teachers, psychologists, physical education teachers, principals, and herself to help solve student problems."

Several of the participants in the workshops became involved in various kinds of continuing education programs for school personnel. Eight supervisors reported that the nurses were active in programs for their nurse colleagues. "As the year has progressed she has led discussions during our monthly meetings of school nurses, arousing considerable awareness among nurses of the need to take a positive attitude toward mental health in working with student problems. She is currently serving as a catalyst among our school nurses providing impetus in our school nursing program for more work in the area of mental health . . . ." "... the wealth of information and experiences she had last summer was shared with other nursing supervisors and through them with the staff nurses in our schools."

Five supervisors commented that the nurses shared some of the knowledge acquired in the workshop with the faculties in their schools. One stated: "/The nurse/ has talked with our faculty concerning the mental health of youngsters and it was an effective presentation."

In the area of collaboration with community agencies, progress was reported in four instances. One comment, for example, was that "/The nurse/ has increased her understanding of the value of including other agencies and community facilities to assist and contribute toward the improvement of the situation by seeking their assistance and working with them."

The nurse's increased participation in the health education program of the school, particularly in the family living aspects, was reported in five instances. One principal stated: "During the school year . . . /the nurse/ gave me more than the usual aid and counsel with problems concerning sex education and family living." Another supervisor reported that the nurse had been "guest speaker in special areas in health education concerned with physical conditions and their influence on one's mental health."

## Summary

This report describes the planning, implementation, and evaluation of a project that was designed to assist nurses in school health to become more effective in their work with children and children's families. During the course of the series of workshops and in the participants' written descriptions of case situations, a clearer picture emerged of both the present and potential contributions of the school nurse to the mental health of children.

After reviewing both factual data and subjective impressions which the workshop staff accumulated during the five years of this project, some observations may be made. The first and most important is that, in the opinion of the staff, the series of workshops accomplished the purposes for which they were designed and perhaps even more. If one may judge by the enthusiastic participation and response of the participants, the workshops helped them to augment their knowledge and skills in dealing with problems in the area of mental health. Comments expressed by the nurses at the time of the workshops, and thereafter, indicate that, for some, it was a deeply personal experience that contributed to their self-understanding as well as to their understanding of children.

The force which motivated the nurses to attend the workshops seemed to be a sincere interest in children, and a desire to help them. In general, the nurses demonstrated the ability to project warmth and to relate to young students but, in many instances, they lacked sophistication in interviewing techniques which would enable the child to explore feelings and clarify problems. Hence, the predominant emphasis in the workshops was upon the acquisition of background knowledge, and the development, practice, and analysis of skills. In the judgment of the teaching staff, most of the nurses made some progress in these areas. Equally significant, perhaps, is the fact that participants, their immediate principals or supervisors, and the workshop staff all noted evidence of increased confidence on the part of the nurses in their work with troubled children and families. This increase in security in itself probably served to decrease the nurses' anxiety and enhance their effectiveness in interpersonal relations.

## Recommendations

A major recommendation arising from this project is that similar kinds of experiences be provided for other nurses currently practicing in the area of school health and for students preparing for these positions. Based on the experiences of the last five years, certain elements of this series of workshops were judged by the staff as essential to success and should be included in similar future endeavors. First, time and effort were allocated to detailed planning prior to the first session and the instructors carried out continuous and concurrent appraisal of their efforts. Adequate preparation for the field experience, an ample teaching staff, and orientation of personnel in the field agencies were of prime importance. Advance planning and somewhat detailed organization probably helped to reduce some anxiety inherent in the field experience. The reference to structure is not meant to connote rigidity, however. Modifications of original plans were made in accordance with the needs of the participants.

The accessibility of an extensive resource library also contributed to the success of the workshops. Various readings in the area of mental health were available in the room in which the sessions were held. Time was provided within the schedule for participants to use these resources and a simple sign-out system made it possible for them to borrow materials overnight. One suggestion the participants made was that, if possible, the time allocated for use of these references be increased. During an evaluation session at the close of the first workshop, they also suggested that the bibliography be sent to workshop participants in advance. This suggestion was adopted and, consequently, the nurses in the succeeding workshops had an opportunity to do background reading prior to the formal class sessions.

The concentration of each of the workshops into a limited time period (two weeks in this case) provided an intensity of experience that contributed to the involvement of each individual participant and to the esprit de corps of the group. For each of these two-week periods, a majority of the participants had limited work, educational, or personal responsibilities outside the workshop. Formal sessions ordinarily occupied the hours from 9:00 A.M. to 4:00 P.M. Informal discussions often lasted until late in the evening. Most members of the workshops occupied adjacent rooms in college residences and planned jointly for evening recreational activities. Thus, a relatively intense group experience accompanied the concentrated educational experience.

The opportunity to apply new knowledge to immediate practice in the field experience was a critical factor in the success of the workshops. Application of theory to practice has frequently been a problem in professional education. The sequence of presentation of new content, opportunity to use the new knowledge which had been acquired, and discussion and evaluation afterwards combined to provide an effective learning experience.

Finally, a spirit of cooperation among the staff was an essential ingredient of the workshop. While each instructor had her major area of responsibility, each also felt free to contribute to the presentations of other staff members. Thus, instruction in the workshops frequently resembled team teaching at its best. The varied backgrounds of staff members enabled each one to contribute to discussions from a slightly different perspective. Cohesiveness was enhanced by the continuity of the staff; two of the same instructors participated in all of the workshops and the same psychiatrist contributed to each of the advanced sessions.

A second recommendation is that efforts be made to develop teaching material in the area of communication with normal, healthy children. Much of the existing material in nurse-patient interaction applies to psychiatric nursing or nursing of ill adults and is not directly applicable to the work of the nurse in the school or other health promotion settings.

A final recommendation is that an instrument or tool be developed for instructor or nurse use in the analysis of process recordings. It was hoped that such a tool would be a by-product of these workshops but it did not materialize.

## Conclusion

Both participants and instructors considered this series of workshops to be an effective learning experience. It is hoped, therefore, that the information contained in this document will serve as a guide for college and university faculties who are interested in a similar undertaking. It is also hoped that it will be useful for those in nursing practice who work closely with children in the hospital, in the home, or at school. The report shows that the stresses felt by children are many and the opportunities for nurses to help alleviate some of the strains are great. This presentation is offered, too, to help stimulate thoughtful consideration of the opportunity for the promotion of mental health in the school and for the improvement of services to children whenever and wherever they are fortunate enough to have the care of a nurse.

TEACHERS COLLEGE COLUMBIA UNIVERSITY

NEW YORK, NEW YORK 10027

Dear

Enclosed is a sample of a letter which is being mailed to invite selected school nurses to our workshop on mental health. I am writing to ask if you have anyone on your staff who has at least a baccalureate degree and two years of experience in school health work whom you would like to recommend and who might be interested in attending. As the enclosed letter indicates transportation costs will be paid for those not within the normal commuting area and a stipend of $100.00 will be provided.

I shall be pleased to extend an invitation to a member of your staff who meets the qualifications outlined above.

Sincerely yours,

Elizabeth C. Stobo
Professor of Nursing Education
Department of Nursing Education

ECS:hjb

TEACHERS COLLEGE COLUMBIA UNIVERSITY

NEW YORK, NEW YORK 10027

Dear

Plans are now being made for a two-week workshop in the area of mental health to be held Monday through Friday from June for experienced school nurses. I am writing to invite you to attend this workshop which will be carried out with a grant from the National Institutes of Mental Health.

The two stated purposes of the workshop are:

1. To provide nurses serving the schools with learning activities based on modern concepts in mental health and psychiatric nursing which will increase the nurses' competence in working in the schools.

2. To identify the skills the nurse in the school health program needs in order to function effectively in the prevention and treatment of emotional disturbance through systematic feedback and evaluation of the nurse's experience in the program provided.

The content of the workshop will include lectures and discussions on growth and development theory and problems which influence developmental tasks. During the two-week period each student will have an opportunity to become acquainted with one hospitalized child on a pediatric service. No plans have been made for workshop participants to give nursing care as such. Various techniques such as interviewing and process recording will be developed by each student. A psychiatrist will participate in some of the discussions and will present some of the lecture material.

There will be no tuition fees as these are covered by the grant. The course will be offered only on a non-credit basis. A stipend of $100 will be made available for each student to help cover living costs plus the cost of a health examination, books and supplies. Transportation costs at tourist rates will be reimbursed for resident students who are not within the normal commuting area.

As indicated in purpose two (above), in order to evaluate this offering we shall be in touch with you after the workshop is over to get your reaction to the workshop activities and the content presented. Also, we shall probably ask your immediate principal(s) or superintendent to respond to a short questionnaire about his views on the influence of the course upon your work with children. When you respond to this letter, will you give me the name and address and title of the superintendent or other person whom we might want to contact at a later date.

Students who accept the invitation to our workshop this year will be invited to return to an advanced workshop to be held in July of 196 , probably during the period of July . Will you let me know by whether or not you are interested in attending these workshops? Because attendance is by invitation only and limited to twenty students, I shall consider your answer as a firm commitment if your response is positive. It will help very much with our planning to have a positive or negative response, and if a response is not received by the opportunity of attending the workshop will be automatically withdrawn. Information about housing facilities will be sent after we hear from you.

I hope you will find it possible to attend these workshops as we are sure you will find it very worthwhile.

Sincerely yours,

Elizabeth C. Stobo
Professor of Nursing Education

ECS/hjb

TEACHERS COLLEGE COLUMBIA UNIVERSITY
NEW YORK, NEW YORK 10027

Dear

Thank you for your letter letting me know that you will attend our Mental Health-School Nurse Workshop to be held June - June 196 . We are delighted that you will be with us.

We anticipate that the workshop will be conducted as follows:

| | |
|---|---|
| 9:00 a.m. - 10:30 a.m. | Lecture |
| 10:30 a.m. - 11:30 a.m. | Coffee Break, Travel, Dress, etc. |
| 11:30 a.m. - 12:30 p.m. | Field Daily |
| 12:30 p.m. - 2:30 p.m. | Lunch, Travel, Discussions (individual and small group) |
| 2:30 p.m. - 4:30 p.m. | Meeting of Total Group |

Enclosed please find a health examination form which has to be returned with a chest X-ray report. We shall need to have a report of a chest X-ray and a health examination completed within six months of the date the workshop begins. Kindly send these reports by June 1.

Housing is available by writing directly to:

Sigbert Borg, Office Manager
Men's Residence Halls
Columbia University
New York, New York 10027

Meals are available at Teachers College Cafeteria, located on the ground floor of Dodge Hall. The hours are 7:00 a.m. - 7:00 p.m. We are enclosing a plan of buildings which will help you to become oriented to the physical layout.

Teachers College is located between Amsterdam Avenue and Broadway and the address is 525 West 120th Street, New York City. My office number is 178 Dodge Hall and the telephone number is Area 212 - 870-4368.

We shall be in touch with you again, however, if there are any questions please do not hesitate to write.

Sincerely yours,

ECS/hjb
Enc.

Elizabeth C. Stobo
Professor of Nursing Education

TEACHERS COLLEGE COLUMBIA UNIVERSITY
NEW YORK, NEW YORK 10027

Dear

We are looking forward to your attendance at the workshop in June and hope that what we have planned will be both worthwhile and interesting. I am enclosing materials which should be helpful in orienting you to Teachers College and to the workshop itself. In addition, we are sending you a bibliography on mental health and other related topics which was compiled for the program in the event that you wish to review the material prior to the workshop. An additional list of readings will be distributed at the conference.

We are asking you to fill out the enclosed questionnaire on what you hope to gain from the conferences. This information will serve as a valuable guide for further planning. Please return the questionnaire to us by June 1st.

As you can see on the schedule, we shall be meeting in Room 539 on the fifth floor of Dodge Hall. The clerk at the Information Desk at the entrance to Teachers College Main Hall will give you directions if the diagrams in the brochure that we sent you earlier are not clear. Either the Broadway Bus No. 104 or the Amsterdam Avenue Bus No. 11 will let you off one-half block from the entrance to Teachers College. The Broadway and 7th Avenue I.R.T. subway stops at 116th Street and Broadway. It is then necessary to walk north four blocks and turn right on 120th Street to reach the main entrance to the College. The exact address is 525 West 120th Street, which is half-way between Broadway and Amsterdam Avenue.

My office is located in Room 178, Dodge Hall and my telephone number is Area Code 212, 870-4368. Miss Dorothy Shoobs who is working with me, has an office in the Institute, Room 702, Dodge Hall. Her telephone number is 870-4143. If we may be of assistance before or after you arrive, we shall be glad to hear from you.

Sincerely yours,

Elizabeth C. Stobo
Professor
Department of Nursing Education

ECS/hjb
Encl.

TEACHERS COLLEGE COLUMBIA UNIVERSITY

NEW YORK, NEW YORK 10027

Dear

It was very nice to have you as a member of our workshop for school nurses conducted under a grant from the National Institites of Mental Health. We are now making plans for the followup activities of the forthcoming year and we are writing to ask each of the workshop participants to select and work with one child during the school year 196 . This will give you an opportunity to try out your skills over a long period of time and it will provide case material for us. Some of the case material will be used for the second Work Conference for our original group. We would like to have you select a child whose problem is of such interest that you would be willing to discuss the problem at the next workshop which is scheduled to be held July

The study should include a brief statement of the child's background (history, physical, emotional, academic status), contacts with the school nurse, and a process recording of at least three contacts with the child.

A process recording is primarily a word picture of the interaction between two (or more) participants in a situation. Included should be: as many direct quotations as possible, statements of the feelings of both participants, and brief analyses of what is going on during the contact (this includes physical and emotional atmosphere and change as well as your interpretation of the psychodynamics involved). Do not use the child's true name, but do include age, grade, and sex.

In looking at these studies, we shall raise questions such as:

Are the nurse's own feelings and reactions included?
Are these feelings examined in relation to the patient?
Do we have direct quotations?
Where do we see application of mental health concepts?
What type of observations are reported?

Please do your recordings on the same type of form used during the workshop. A sample is enclosed.

Will you kindly make plans to have your study, including process recordings, reach us around May 1, 196 . Having these reports in May will give us an opportunity to do whatever preliminary planning may be necessary before the workshop begins during the summer of 196 .

Enclosed is a stamped self-addressed post card assuring us that you plan on attending next year. We shall need a process recording from each person whether or not she will attend.

Sincerely yours,

Elizabeth C. Stobo
Professor
Division of Nursing Education

ECS:hjb
Enclosure

TEACHERS COLLEGE COLUMBIA UNIVERSITY

NEW YORK, NEW YORK 10027

Dear

We are delighted that you will be with us again this year and are looking forward to the group reunion As can be expected, there is some preparatory work that must be done before the workshop.

Enclosed is a health examination form similar to the one you had to submit last year. Again, we shall need a report of a chest X-ray and a health examination completed within six months of the date the workshop begins. May I please have these reports by July 1st.

Housing will again be available by writing directly to:

Sigbert Borg, Office Manager
Men's Residence Halls
Columbia University
New York, New York 10027

As you will recall, meals are available at Teachers College Cafeteria, located on the ground floor of Dodge Hall. The hours are 7 a.m. - 7 p.m.

Teachers College is located between Amsterdam Avenue and Broadway and the address is 525 West 120th Street, New York City. My office number is 178, Dodge Hall and the telephone number is Area 212 - 870-4369.

If there are any questions, please do not hesitate to write.

Sincerely yours,

Elizabeth C. Stobo
Professor
Nursing Education

ECS/hjb
Encl.

TEACHERS COLLEGE COLUMBIA UNIVERSITY

NEW YORK, NEW YORK 10027

Dear

We are in the process of preparing for our workshop in July. Enclosed is the proposed schedule outlining the program. We would like to have your suggestions as to the content that you would like included in the conferences so a questionnaire on expectations is also enclosed.

During the past year you have probably given much thought to additional materials that could be covered in the workshop which would be helpful to you in your mental health functions. The information from the questionnaire telling us what you hope to gain from the workshop will help us in our final planning. Please return the completed questionnaire as soon as possible.

If you have not as yet submitted your process recording due May 1, 196 please send this to us. We are looking forward to seeing you in July.

Sincerely yours,

Elizabeth C. Stobo
Professor
Nursing Education

ECS:hjb
Encls.
Schedule
Questionnaire

TEACHERS COLLEGE COLUMBIA UNIVERSITY

NEW YORK, NEW YORK 10027

Dear

You have attended one or both of the workshops on mental health for school nurses which was carried out under a grant from the National Institute of Mental Health. As you may recall in our original letter of invitation, we stated that the purposes of the workshops were as follows:

1. To provide nurses serving the schools with learning activities based on modern concepts in mental health and psychiatric nursing which will increase the nurses' competence in working in the schools.

2. To identify the skills the nurse in the school health program needs in order to function effectively in the prevention and treatment of emotional disturbance through systematic feedback and evaluation of the nurse's experience in the program provided.

In order to determine how well we are meeting our objectives in helping you to obtain the content which you feel is essential, we are writing to ask you to kindly answer the questions on the enclosed forms. We appreciate your cooperation in this endeavor and we shall look forward to having your reply within the next two weeks.

Sincerely yours,

Elizabeth C. Stobo
Professor
Division of Nursing Education

ECS/hjb
Encl.

TEACHERS COLLEGE COLUMBIA UNIVERSITY

NEW YORK, NEW YORK 10027

Dear

Last year under a grant from the National Institutes of Mental Health, Teachers College, Columbia University held a workshop on mental health for school nurses. of your staff attended this workshop which was limited to twenty participants. In the original letter of invitation we stated "we shall probably ask your immediate principal(s) or supervisor to respond to a short questionnaire about his views on the influence of the course upon your work with children." Your name was submitted in response to this request. I am writing to ask you to kindly send us your evaluation of the changes, if any, noted approach in dealing with children during the past year. We are particularly interested in examples of her work performance which demonstrate any gains in her understanding of mental health concepts and in her functioning in the mental health aspects of school nursing. We are collecting this information by letter rather than questionnaire.

Each participant is being sent a checklist type of questionnaire asking her to respond to the degree of influence (great. some, little, none) she believes the workshop has had on her knowledge, understanding and abilities in the area of mental health and school nursing. The items to which she is asked to respond include knowledge and understanding of human growth and development, psychodynamics, inter-personal and communication theory, current mental health concepts and practices; also abilities in assessing needs of children and the situation, interviewing and counseling, collaborating with other workers in the school and in the community.

We shall welcome comments from you to help us evaluate our efforts.

Sincerely yours,

Elizabeth C. Stobo
Professor
Division of Nursing Education

ECS/hjb

TEACHERS COLLEGE - COLUMBIA UNIVERSITY
Division of Nursing Education

Example of SCHEDULE

## WORK CONFERENCE ON THE SCHOOL NURSE IN MENTAL HEALTH

June - June , 196

### FIRST WEEK

Monday

| | |
|---|---|
| 9:00 - 10:30 | Introductions, Purpose of Workshop, Plans, Requirements<br>Coffee Break |
| 10:30 - 12:30 | Growth and Development Theory |
| 12:30 - 1:30 | Lunch |
| 1:30 - 4:30 | Workshop planning: registration, field assignments, process recording |

Tuesday

| | |
|---|---|
| 9:00 - 10:30 | Growth and Development |
| 10:30 - 11:30 | Coffee Break, Travel, Dress, etc. |
| 11:30 - 12:30 | Field |
| 12:30 - 1:30 | Lunch |
| 1:30 - 2:30 | Small Group Discussion |
| 2:30 - 4:30 | Seminar, Total Group discussion of feelings, content on establishing relationships |

Wednesday

| | |
|---|---|
| 9:00 - 10:30 | Growth and Development |
| 10:30 - 11:30 | Coffee Break, Travel, Dress, etc. |
| 11:30 - 12:30 | Field |
| 12:30 - 1:30 | Lunch |
| 1:30 - 2:30 | Small Group Discussion |
| 2:30 - 4:30 | Communications |

Thursday

| | |
|---|---|
| 9:00 - 10:30 | Growth and Development |
| 10:30 - 11:30 | Coffee Break, Travel, Dress |
| 11:30 - 12:30 | Field |
| 12:30 - 1:30 | Lunch, Travel |
| 1:30 - 2:30 | Small Group Discussion |
| 2:30 - 4:30 | Communications, Film: "Task of the Listener" |

Friday

| | |
|---|---|
| 9:00 - 10:30 | Growth and Development |
| 10:30 - 11:30 | Coffee Break, Travel, Dress |
| 11:30 - 12:30 | Field |
| 12:30 - 1:30 | Lunch, Travel |
| 1:30 - 2:30 | Small Group Discussion |
| 2:30 - 4:30 | Discussion of cases with psychiatrist |

## SECOND WEEK

June - June , 196

Monday

| | |
|---|---|
| 9:00 - 10:30 | Film: "Enemy In Myself" - Discussion |
| 10:30 - 11:30 | Coffee Break, Travel, Dress |
| 11:30 - 12:30 | Field |
| 12:30 - 1:30 | Lunch, Travel |
| 1:30 - 2:30 | Small Group Discussion |
| 2:30 - 4:30 | Discussion of cases with psychiatrist |

Tuesday

| | |
|---|---|
| 9:00 - 10:30 | Relating experience to growth and development as seen in various situations, especially home and school |
| 10:30 - 11:30 | Coffee Break, Travel, Dress |
| 11:30 - 12:30 | Field |
| 12:30 - 1:30 | Lunch, Travel |
| 1:30 - 2:30 | Small Group Discussion |
| 2:30 - 4:30 | Discussion of cases with psychiatrist |

Wednesday

| | |
|---|---|
| 9:00 - 10:30 | Relating experience to growth and development as seen in various situations, especially home and school.<br>Film: "Afraid of School" - Discussion |
| 10:30 - 11:30 | Coffee Break, Travel, Dress |
| 11:30 - 12:30 | Field |
| 12:30 - 1:30 | Lunch, Travel |
| 1:30 - 2:30 | Small Group Discussion |
| 2:30 - 4:30 | Discussion of cases with psychiatrist |

Thursday

| | |
|---|---|
| 9:00 - 10:30 | Relating experience to growth and development as seen in various situations, especially home and school |
| 10:30 - 10:45 | Coffee Break |
| 10:45 - 11:45 | Individual or small group discussions on process recordings |
| 12:30 - 1:30 | Lunch |
| 1:30 - 2:30 | Small Group Discussion |
| 2:30 - 4:30 | Seminar - total group |

Friday

| | |
|---|---|
| 9:00 - 3:00 | The School Nurse in Mental Health. Film: "Bold New Approach" and Discussion. Summary, Evaluation, Recommendations |

TEACHERS COLLEGE - COLUMBIA UNIVERSITY
Division of Nursing Education

Work Conference on the School Nurse in Mental Health

Example of SCHEDULE of WORK CONFERENCE
(Second in the series)
July - July , 196

## FIRST WEEK

### Monday

| | |
|---|---|
| 9:00 - 10:00 | Introductions. |
| 10:00 - 12:00 | Mental Mechanisms. |
| 12:00 - 1:00 | Lunch. |
| 1:00 - 4:00 | Film. "Aggressive Child." Discussion. |

### Tuesday

| | |
|---|---|
| 9:00 - 10:00 | Treatment Modalities. |
| 10:00 - 12:00 | Discussions with psychiatrist. |
| 12:00 - 1:00 | Lunch. |
| 1:00 - 1:30 | Individual conferences on Process Recordings. |
| 1:30 - 2:30 | Film. "In and Out of Psychosis." Discussion. |
| 2:30 - 4:00 | Theories of Psychiatry - crisis theory, group theory. |

### Wednesday

| | |
|---|---|
| 9:00 - 10:00 | Theories of Psychiatry, continued. |
| 10:00 - 12:00 | Discussions with psychiatrist. |
| 12:00 - 1:00 | Lunch. |
| 1:00 - 1:30 | Individual conferences on Process Recordings. |
| 1:30 - 4:00 | Preparation for field: Observations, Treatment Modalities. |

### Thursday

| | |
|---|---|
| 9:00 - 4:00 | Field, observations, lectures and discussions. |

### Friday

| | |
|---|---|
| 9:00 - 10:00 | Post field discussion. |
| 10:00 - 12:00 | Discussions with psychiatrist. |
| 12:00 - 1:00 | Lunch. |
| 1:00 - 1:30 | Individual conferences on Process Recordings |
| 1:30 - 3:00 | Discussion |

## SECOND WEEK

July - July , 196

**Monday**

| | |
|---|---|
| 9:00 - 10:00 | Implications for the role of the school nurse. |
| 10:00 - 12:00 | Discussions with psychiatrist. |
| 12:00 - 1:00 | Lunch. |
| 1:00 - 2:00 | Individual conferences on Process Recordings. |
| 2:00 - 4:00 | Observational skills and the school nurse. Use of diagnostic data. Process recordings as a vehicle. Preventive opportunities. |

**Tuesday**

| | |
|---|---|
| 9:00 - 10:00 | Film. "The World of Schizophrenia." |
| 10:00 - 12:00 | Discussion. |
| 12:00 - 1:00 | Lunch. |
| 1:00 - 1:30 | Individual conferences on Process Recordings. |
| 1:30 - 4:00 | Small group analysis followed by large group analysis of assigned case situation. |

**Wednesday**

| | |
|---|---|
| 9:00 - 12:00 | Counseling Process. The role of the nurse. |
| 12:00 - 1:00 | Lunch. |
| 1:00 - 1:30 | Individual conferences on Process Recordings |
| 1:30 - 4:00 | Interviewing technics through appraisal of technics used in Situations presented in worksheets. |

**Thursday**

| | |
|---|---|
| 9:00 - 10:30 | Film. "Bright Boy - Bad Scholar." Discussion. |
| 10:30 - 12:00 | Self and instructor analysis of process recordings kept of nurse-student interaction. |
| 12:00 - 1:00 | Lunch. |
| 1:00 - 4:00 | Continue analysis of process recordings and discussion of mental health activities during past school year. |

**Friday**

| | |
|---|---|
| 9:00 - 3:00 | Summing up on process recordings' workshop implication for the school nurse. |

## Table 1

## Geographic Distribution Of Workshop Participants By State

| State | Number of Workshop Participants | | | | |
|---|---|---|---|---|---|
| | Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
| Alabama | 0 | 0 | 1 | 0 | 1 |
| Alaska | 0 | 0 | 2 | 0 | 2 |
| California | 2 | 1 | 0 | 0 | 3 |
| Colorado | 1 | 0 | 0 | 1 | 2 |
| Connecticut | 3 | 0 | 0 | 0 | 3 |
| District of Columbia | 0 | 0 | 0 | 1 | 1 |
| Idaho | 0 | 0 | 1 | 0 | 1 |
| Illinois | 2 | 2 | 0 | 2 | 6 |
| Kansas | 0 | 0 | 1 | 0 | 1 |
| Maryland | 0 | 0 | 0 | 2 | 2 |
| Massachusetts | 0 | 2 | 0 | 0 | 2 |
| Michigan | 0 | 0 | 0 | 1 | 1 |
| Minnesota | 0 | 3 | 1 | 3 | 7 |
| New Hampshire | 1 | 1 | 0 | 0 | 2 |
| New Jersey | 0 | 4 | 3 | 1 | 8 |
| New Mexico | 0 | 0 | 1 | 0 | 1 |
| New York | 7 | 1 | 7 | 6 | 21 |
| Ohio | 0 | 0 | 1 | 0 | 1 |
| Pennsylvania | 0 | 4 | 0 | 0 | 4 |
| Rhode Island | 0 | 1 | 0 | 0 | 1 |
| South Carolina | 1 | 0 | 0 | 0 | 1 |
| Texas | 2 | 1 | 1 | 1 | 5 |
| Virginia | 0 | 0 | 1 | 1 | 2 |
| Washington | 1 | 0 | 0 | 0 | 1 |
| Wyoming | 0 | 0 | 0 | 1 | 1 |
| TOTAL | 20 | 20 | 20 | 20 | 80 |

## Table 2
## Age Of Workshop Participants Upon Entrance Into Workshop

| Age | Number of Workshop Participants<br>Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
|---|---|---|---|---|---|
| 25 - 29 | 2 | 0 | 2 | 2 | 6 |
| 30 - 34 | 0 | 2 | 1 | 2 | 5 |
| 35 - 39 | 0 | 1 | 1 | 3 | 5 |
| 40 - 44 | 8 | 5 | 7 | 3 | 23 |
| 45 - 49 | 6 | 5 | 1 | 5 | 17 |
| 50 - 54 | 2 | 5 | 4 | 1 | 12 |
| 55 - 59 | 1 | 2 | 2 | 3 | 8 |
| 60 - 64 | 1 | 0 | 2 | 1 | 4 |
| TOTAL | 20 | 20 | 20 | 20 | 80 |

## Table 3
## Marital Status of Workshop Participants

| Marital Status | Number of Workshop Participants<br>Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
|---|---|---|---|---|---|
| Single | 8 | 9 | 9 | 11 | 37 |
| Married | 10 | 7 | 9 | 8 | 34 |
| Widowed, Separated or Divorced | 2 | 4 | 2 | 1 | 9 |
| TOTAL | 20 | 20 | 20 | 20 | 80 |

## Table 4
## Numbers Of Workshop Participants Having Children

| Number of Children | Number of Workshop Participants<br>Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
|---|---|---|---|---|---|
| 1 | 3 | 3 | 3 | 1 | 10 |
| 2 | 3 | 2 | 3 | 1 | 9 |
| 3 | 2 | 1 | 2 | 1 | 6 |
| 4 | 0 | 0 | 0 | 0 | 0 |
| 5 | 1 | 0 | 0 | 0 | 1 |
| TOTAL | 9 | 6 | 8 | 3 | 26 |

Table 5
Educational Background Of Workshop Participants

| Education | Number of Workshop Participants<br>Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
|---|---|---|---|---|---|
| Diploma in nursing | 16 | 17 | 16 | 14 | 63 |
| Bachelors degree in nursing | 19 | 18 | 16[1] | 18 | 71 |
| Bachelors degree in other than nursing[2] | 1 | 2 | 4 | 3[3] | 10 |
| Masters degree in nursing | 6 | 5 | 5 | 3 | 19 |
| Masters degree in other than in nursing[4] | 2 | 3 | 3 | 3 | 11 |
| Doctoral study | 0 | 1[5] | 1[6] | 0 | 2 |
| Other college courses (non-degree) | 11 | 9 | 10 | 12 | 42 |
| Associate of Arts degree in other than nursing | 1 | 0 | 0 | 1 | 2 |

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[1] Of this group, two individuals held two bachelors degrees in nursing.

[2] Of this group, three held bachelors degrees in health education, four in general education, one in sociology, and one in psychology. Of this group, three had subsequent masters degrees in nursing.

[3] One individual in this group held a bachelors degree in a field other than nursing in addition to a bachelors degree in nursing.

[4] Of this group, four individuals held masters degrees in education, two in educational administration, two in health education, one in health and physical education, one in administration and supervision, and one in guidance and counseling.

[5] This individual was engaged in a doctoral program leading to a Ph.D in the humanities.

[6] This individual was engaged in a doctoral program leading to an Ed.D in nursing education.

## Table 6
## Educational Background Of Workshop Participants In School Nursing, Psychiatric Nursing, Public Health Nursing, And Pediatric Nursing.

| | Number of Workshop Participants | | | | |
|---|---|---|---|---|---|
| Subject | Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
| Education in school nursing | 11 | 13 | 15 | 14 | 53 |
| Undergraduate course with field experience | 5 | 4 | 6 | 2 | 17 |
| Undergraduate course without field experience | 5 | 8 | 6 | 0 | 19 |
| Graduate course with field experience | 2 | 0 | 2 | 4 | 8 |
| Graduate course without field experience | 2 | 7 | 7 | 9 | 25 |
| No formal course in school nursing | 9 | 7 | 5 | 5 | 26 |
| Education in psychiatric nursing | 17 | 17 | 18 | 17 | 69 |
| Undergraduate course with field experience | 12 | 11 | 14 | 14 | 51 |
| Undergraduate course without field experience | 5 | 5 | 3 | 3 | 16 |
| Graduate course with field experience | 0 | 0 | 2 | 0 | 2 |
| Graduate course without field experience | 0 | 3 | 0 | 0 | 3 |
| No formal course in psychiatric nursing | 3 | 3 | 2 | 3 | 11 |
| Education in public health nursing | 20 | 19 | 20 | 20 | 79 |
| Undergraduate course with field experience | 15 | 14 | 15 | 20 | 64 |
| Undergraduate course without field experience | 4 | 4 | 3 | 0 | 11 |
| Graduate course with field experience | 4 | 1 | 2 | 2 | 9 |
| Graduate course without field experience | 4 | 5 | 3 | 3 | 15 |
| No formal course in public health nursing | 0 | 1 | 0 | 0 | 1 |
| Graduate education in pediatric nursing | 2 | 0 | 2 | 1 | 5 |
| Graduate course with field experience | 2 | 0 | 1 | 1 | 4 |
| Graduate course without field experience | 0 | 0 | 0 | 0 | 0 |
| Child psychiatric nursing with field experience | 0 | 0 | 1 | 0 | 1 |

Table 7

Workshop Participants' Experience In School Nursing: Length Of Time

| Years in School Nursing | Number of Workshop Participants<br>Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
|---|---|---|---|---|---|
| 1 - 5 | 6 | 1 | 4 | 4 | 15 |
| 6 - 10 | 7 | 8 | 4 | 7 | 26 |
| 11 - 15 | 3 | 5 | 6 | 5 | 19 |
| 16 - 20 | 4 | 5 | 2 | 3 | 14 |
| 21 - 25 | 0 | 1 | 2 | 0 | 3 |
| 26 or over | 0 | 0 | 1 | 1 | 2 |
| TOTAL | 20 | 20 | 19* | 20 | 79 |

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* One student had no experience in specialized school nursing but twenty-seven years in generalized public health nursing which included school work.

Table 8
Workshop Participants' Experience In School Nursing: Grade Levels

| Grade Levels | Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
|---|---|---|---|---|---|
| | Number of Workshop Participants | | | | |
| Elementary only | 7 | 2 | 3 | 6 | 18 |
| Junior high school only | 0 | 1 | 1 | 2 | 4 |
| Senior high school only | 1 | 0 | 0 | 0 | 1 |
| Elementary and junior high school | 4 | 2 | 2 | 5 | 13 |
| Elementary and senior high school | 0 | 0 | 1 | 1 | 2 |
| Junior and senior high school | 0 | 0 | 1 | 1 | 2 |
| Elementary, junior, and senior high school | 8 | 15 | 12 | 5 | 40 |
| College | 2 | 0 | 0 | 1 | 3* |
| Total elementary | 19 | 19 | 18 | 17 | 73 |
| Total junior high school | 12 | 18 | 16 | 13 | 59 |
| Total senior high school | 9 | 15 | 14 | 7 | 45 |

* These three individuals had also had experience in elementary, junior and senior high schools.

Table 9
Workshop Participants' Experience In School Nursing: Types Of Schools

| Type of School | Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
|---|---|---|---|---|---|
| | Number of Workshop Participants | | | | |
| Public only | 11 | 14 | 12 | 13 | 50 |
| Parochial only | 1 | 1 | 0 | 1 | 3 |
| Both public and parochial | 8 | 5 | 8 | 6 | 27 |
| TOTAL | 20 | 20 | 20 | 20 | 80 |

Table 10
Workshop Participants' Past Work Experience Other Than School Nursing

| Field of Nursing | Number of Workshop Participants<br>Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
|---|---|---|---|---|---|
| Public health nursing (staff position only) | 11 | 12 | 10 | 11 | 44 |
| Public health nursing (supervisor or administrator) | 3 | 3 | 5 | 1 | 12 |
| Hospital nursing (staff or head nurse position) | 9 | 15 | 8 | 15 | 47 |
| Hospital nursing (supervisor or administrator) | 6 | 2 | 2 | 5 | 15 |
| Private duty nursing | 1 | 2 | 1 | 1 | 5 |
| Military nurse corps and reserve | 5 | 1 | 1 | 0 | 7 |
| Nursing education - diploma program | 2 | 2 | 3 | 3 | 10 |
| Nursing education - collegiate program | 0 | 0 | 1 | 1 | 2 |
| Nursing education - practical nurse program | 0 | 2 | 1 | 0 | 3 |

Other:
Nurse in physician's office (2)
Nurse in occupational or industrial health (2)
Nurse in summer camp (2)
Consultant in maternity center (1)
Missionary nurse (1)
Research (1)
State Department of Education - Assistant in Health Education (1)
Public health educator (1)
Executive secretary in voluntary health agency (1)
Instructor in nutrition (1)
Instructor in dental school (1)
Clerk (1)
Elementary teacher (2)
Special education teacher (1)

### Table 11
### Workshop Participants' Experience In Public Health Nursing: Length Of Service

| Number of Years | Number of Workshop Participants<br>Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
|---|---|---|---|---|---|
| 0 | 8 | 8 | 10 | 9 | 35 |
| 1 or less | 2 | 1 | 0 | 3 | 6 |
| 2 - 5 | 4 | 8 | 5 | 7 | 24 |
| 6 - 10 | 3 | 1 | 0 | 1 | 5 |
| 11 - 15 | 0 | 0 | 2 | 0 | 2 |
| 16 - 20 | 3 | 1 | 1 | 0 | 5 |
| over 20 | 0 | 1 | 2 | 0 | 3 |
| TOTAL With Experience | 12 | 12 | 10 | 11 | 45 |

### Table 12
### Workshop Participants' Experience In Public Health Nursing: Type Of Employing Agency

| Type of Agency | Number of Workshop Participants<br>Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
|---|---|---|---|---|---|
| Official | 9 | 4 | 5 | 8 | 26 |
| Voluntary | 3 | 5 | 1 | 3 | 12 |
| Both Official and Voluntary | 0 | 3 | 4 | 0 | 7 |

### Table 13
### Workshop Participants' Experience In Public Health Nursing: Positions Held

| Position | Number of Workshop Participants<br>Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
|---|---|---|---|---|---|
| Staff nurse | 11 | 12 | 10 | 11 | 44 |
| Supervisor | 2 | 2 | 4 | 1 | 9 |
| Administrator | 1 | 1 | 1 | 0 | 3 |

### Table 14

### Workshop Participants' Experience In Psychiatric Nursing

| | Number of Workshop Participants | | | | |
|---|---|---|---|---|---|
| Number of Years | Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
| 0 | 16 | 16 | 16 | 19 | 67 |
| 1 or less | 3 | 3 | 4 | 0 | 10 |
| over 1 | 1* | 1** | 0 | 1** | 3 |
| TOTAL With Experience | 4 | 4 | 4 | 1 | 13 |

* This individual had two years of experience.
** These two individuals each had ten years of experience.

### Table 15

### Workshop Participants' Position At Entrance Into Workshops: Title

| Title | Number of Workshop Participants<br>Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
|---|---|---|---|---|---|
| School nurse[1] | 13 | 15 | 15 | 16 | 59 |
| Supervisor[2] | 3 | 3 | 2 | 4 | 12 |
| Coordinator[3] | 1 | 1 | 3 | 0 | 5 |
| Consultant[4] | 2 | 0 | 0 | 0 | 2 |
| Director[5] | 0 | 1 | 0 | 0 | 1 |
| Health counselor | 1 | 0 | 0 | 0 | 1 |
| TOTAL | 20 | 20 | 20 | 20 | 80 |

1. This category includes the following position titles:
   school nurse, school nurse-teacher, nurse-teacher, teacher-nurse, staff nurse, school public health nurse.
2. This category includes the following position titles:
   head nurse, senior school nurse, school nursing supervisor, assistant supervisor, supervisor of school health services, supervisor - office of nursing.
3. This category includes the following position titles:
   coordinator-school nurse teachers, health coordinator, coordinator of health program.
4. This category includes the following position titles:
   consultant nurse - school health, teacher-nurse consultant.
5. This category includes the following position title:
   director of public health nursing services.

Table 16

Workshop Participants' Position At Entrance Into Workshops: Employer

| Employer | Number of Workshop Participants<br>Workshop 1 | Workshop 2 | Workshop 3 | Workshop 4 | Total |
|---|---|---|---|---|---|
| School district | 19 | 18 | 19 | 17 | 73 |
| Local official public health agency | 0 | 2 | 1 | 3 | 6 |
| State Board of Health | 1 | 0 | 0 | 0 | 1 |
| TOTAL | 20 | 20 | 20 | 20 | 80 |

### Table 17

### Participants' Evaluation of Workshop

| ITEM | DEGREE OF INFLUENCE | | | | | |
|---|---|---|---|---|---|---|
| | Great | Some | Little | None | No Ans. | Total |
| 1. Knowledge of growth and development | 20 | 41 | 12 | 1 | 0 | 74 |
| 2. Ability to identify signs and symptoms of underlying emotional problems | 28 | 42 | 4 | 0 | 0 | 74 |
| 3. Knowledge of drugs used in treatment of emotional disturbances | 12 | 28 | 27 | 7 | 0 | 74 |
| 4. Knowledge of psychological and psychiatric terminology | 13 | 40 | 17 | 4 | 0 | 74 |
| 5. Ability to interview children and others | 40 | 31 | 2 | 0 | 1 | 74 |
| 6. Awareness of community resources | 10 | 26 | 31 | 7 | 0 | 74 |
| 7. Use of community resources for mental health and other problems | 10 | 31 | 29 | 4 | 0 | 74 |
| 8. Ability to assess more total needs of children | 45 | 25 | 4 | 0 | 0 | 74 |
| 9. Willingness to discuss emotional problems with parents, school staff, etc. | 39 | 27 | 7 | 1 | 0 | 74 |
| 10. Ability to motivate parents and others to seek help with emotional problems | 31 | 34 | 8 | 1 | 0 | 74 |
| 11. Understanding of multiple factors which influence mental health problems | 36 | 33 | 5 | 0 | 0 | 74 |
| 12. Attitudes or feelings toward children and parents | 33 | 31 | 10 | 0 | 0 | 74 |
| 13. Interest in helping children and others with mental health problems | 42 | 24 | 6 | 1 | 1 | 74 |

| ITEM | DEGREE OF INFLUENCE | | | | | |
|---|---|---|---|---|---|---|
| | Great | Some | Little | None | No Ans. | Total |
| 14. Knowledge of trends and goals of community mental health programs | 18 | 43 | 10 | 2 | 1 | 74 |
| 15. Understanding of modern psychiatric concepts and practices | 21 | 43 | 9 | 1 | 0 | 74 |
| 16. Knowledge of communication theory, eg. verbal and non-verbal modes | 43 | 27 | 4 | 0 | 0 | 74 |
| 17. Knowledge of interpersonal theory | 29 | 34 | 8 | 2 | 1 | 74 |
| 18. Awareness of kinds of common crisis occurring in childhood which may affect mental health of child | 32 | 37 | 4 | 0 | 1 | 74 |
| 19. Understanding of family dynamics | 19 | 45 | 7 | 2 | 1 | 74 |
| 20. Ability to gather more accurate and complete health and developmental histories | 26 | 30 | 15 | 2 | 1 | 74 |
| 21. Awareness of attitudes of children, parents and others toward me | 42 | 23 | 8 | 1 | 0 | 74 |
| 22. Ability to plan the care of an individual or group of children | 11 | 38 | 21 | 2 | 2 | 74 |
| 23. Ability to teach in the health area | 12 | 31 | 25 | 5 | 1 | 74 |
| 24. Interpersonal relations with school personnel or others | 27 | 43 | 4 | 0 | 0 | 74 |
| 25. Ability to use a psychotherapeutic approach | 19 | 35 | 16 | 2 | 2 | 74 |
| 26. Ability to identify crisis situations involving children which may require intervention | 29 | 31 | 13 | 0 | 1 | 74 |
| 27. Feelings of confidence in discussing mental health needs or problems | 32 | 36 | 6 | 0 | 0 | 74 |
| 28. Ability to interpret the mental health needs or problems of children to psychiatric and other specialists | 23 | 38 | 10 | 3 | 0 | 74 |

| ITEM | DEGREE OF INFLUENCE | | | | | |
|---|---|---|---|---|---|---|
| | Great | Some | Little | None | No Ans. | Total |
| 29. Ability to make referrals for psychiatric consultation | 20 | 35 | 15 | 3 | 1 | 74 |
| 30. Ability to use psychiatric or other mental health consultants to understand needs and behavior of children | 28 | 28 | 11 | 5 | 2 | 74 |
| 31. Ability to deal with home visits | 15 | 30 | 21 | 8 | 0 | 74 |
| 32. Ability to study and analyze own feelings and behavior toward others | 52 | 18 | 4 | 0 | 0 | 74 |
| 33. Personal growth and life | 36 | 33 | 4 | 0 | 1 | 74 |
| 34. Objectivity in approach to others | 36 | 31 | 6 | 0 | 1 | 74 |
| 35. More self confidence in dealing with emotional problems | 38 | 31 | 5 | 0 | 0 | 74 |
| 36. Ability to do more complete recordings | 32 | 33 | 9 | 0 | 0 | 74 |
| 37. Desire to work with school personnel on mental health needs of children | 40 | 26 | 8 | 0 | 0 | 74 |
| 38. Understanding of roles and functions of the school nurse in mental health area | 46 | 24 | 4 | 0 | 0 | 74 |
| 39. Reading or using reference material on mental health and psychiatry | 42 | 27 | 5 | 0 | 0 | 74 |
| 40. Telephone contacts with parents | 19 | 35 | 15 | 4 | 1 | 74 |
| 41. Feelings toward parents of emotionally disturbed children | 28 | 33 | 11 | 1 | 1 | 74 |
| 42. Ability to work with staff of other community agencies on mental health problems and programs | 22 | 32 | 18 | 1 | 1 | 74 |
| 43. Ability to interpret the goals and practices of the mental health field to families, school staff, etc. | 29 | 36 | 8 | 1 | 0 | 74 |

| ITEM | DEGREE OF INFLUENCE | | | | | |
|---|---|---|---|---|---|---|
| | Great | Some | Little | None | No Ans. | Total |
| 44. Spending time with emotionally upset children and others | 38 | 20 | 14 | 1 | 1 | 74 |
| 45. Spending time with parents or other family members | 19 | 33 | 17 | 4 | 1 | 74 |
| 46. Desire to pursue more studies on mental health and other related areas in school nursing | 60 | 12 | 1 | 1 | 0 | 74 |
| 47. Relationships with the guidance counselor(s) in the schools | 22 | 29 | 13 | 4 | 6 | 74 |
| 48. Relationships with teachers in the school | 27 | 32 | 11 | 3 | 1 | 74 |
| 49. Relationships with principal(s) in the school | 25 | 30 | 15 | 3 | 1 | 74 |
| 50. Relationships with ______________ in the school (fill in this one) | 36 | 17 | 7 | 0 | 14 | 74 |
| 51. Understanding of ways that school nurse can promote positive mental health in the school | 35 | 32 | 7 | 0 | 0 | 74 |
| 52. Ability to function as a team member with others on problems of children | 38 | 23 | 12 | 1 | 0 | 74 |
| 53. Understanding of unconscious motivation-determinants of behavior | 31 | 32 | 8 | 0 | 3 | 74 |
| 54. Relationships with superiors | 16 | 42 | 15 | 0 | 1 | 74 |
| 55. Knowledge of mental health principles and practices | 29 | 42 | 3 | 0 | 0 | 74 |
| 56. Ability to counsel children on problems | 26 | 43 | 5 | 0 | 0 | 74 |
| 57. Ability to counsel parents on problems and needs of children | 22 | 47 | 4 | 0 | 1 | 74 |

| ITEM | DEGREE OF INFLUENCE | | | | | |
|---|---|---|---|---|---|---|
| | Great | Some | Little | None | No Ans. | Total |
| 58. Ability to help teachers understand mental health needs and behavior of children | 25 | 42 | 7 | 0 | 0 | 74 |
| 59. Ability to help teachers understand own behavior and its effects on children | 17 | 37 | 17 | 3 | 0 | 74 |
| 60. Insight on your own attitude and behavior and its effects on children and others | 53 | 18 | 3 | 0 | 0 | 74 |

Table 18

"Unmet Needs" in School Mental Health Identified by Workshop Participants

| "Unmet Needs" | Number of Workshop Participants<br>Workshop 1 | Workshop 2 | Workshop 3 | Total |
|---|---|---|---|---|
| Increased mental health facilities in the community | 5 | 6 | 4 | 15 |
| In-service education and better preparation of school staff in area of mental health | 5 | 5 | 5 | 15 |
| Better communication and cooperation between school staff in mental health matters | 4 | 5 | 5 | 14 |
| Increase in school nurse's knowledge and self-understanding; evaluation of present nursing methods | 3 | 6 | 2 | 11 |
| Increased mental health personnel in the school | 4 | 3 | 2 | 9 |
| Adequate time and facilities for work with individuals and groups | 0 | 2 | 4 | 6 |
| Earlier identification of children with emotional difficulties | 1 | 1 | 2 | 4 |
| Reduction of stress within the school environment | 1 | 1 | 2 | 4 |
| Comprehensive long-range planning and follow-up | 0 | 0 | 3 | 3 |

Table 19

Workshop Participants' Opinions Regarding "Additional Information" Necessary for More Competent Work in School Mental Health

| | Number of Workshop Participants | | | |
|---|---|---|---|---|
| | Workshop 1 | Workshop 2 | Workshop 3 | Total |
| Further educational experiences similar to those offered in the workshops | 2 | 5 | 4 | 11 |
| Knowledge and practice in counseling | 0 | 3 | 5 | 8 |
| Knowledge of child psychology and psychiatry | 2 | 3 | 2 | 7 |
| Knowledge related to promotion of cooperation and positive interpersonal relations among school and community staff | 1 | 4 | 2 | 7 |
| Knowledge of group process and techniques | 3 | 0 | 2 | 5 |
| Self-understanding | 0 | 2 | 2 | 4 |
| Further explorations and clarification of the school nurse's role | 1 | 1 | 2 | 4 |

Table 20

Summary of Supervisor's Comments in the Areas of Understandings, Attitudes, and Practice

| | Number of Comments Reporting Improvement |
|---|---|
| I Acquired Understandings | 37 |
| A. Insight and understanding of pupils | 20 |
| B. Awareness of mental health problems | 15 |
| C. Understanding of parents' attitudes and concerns | 1 |
| D. Understanding of realistic goals | 1 |
| II Acquired Attitudes | 23 |
| A. Self-confidence | 6 |
| B. Tolerance, acceptance, patience | 6 |
| C. Interest and enthusiasm in mental health projects | 3 |
| D. Cooperation | 2 |
| E. Objectivity | 3 |
| F. Interest in further education | 2 |
| G. Interest in professional organizations | 1 |
| III Observed Practice | 88 |
| A. Work with individual students and staff | 32 |
| B. Work with parents | 11 |
| C. Collaboration with school co-professionals | 23 |
| D. Continuing education for nurses | 8 |
| E. Continuing education for other faculty | 5 |
| F. Collaboration with community agencies | 4 |
| G. Participation in health education program | 5 |

DEPARTMENT OF NURSING EDUCATION
TEACHERS COLLEGE, COLUMBIA UNIVERSITY

WORK CONFERENCE ON THE SCHOOL NURSE IN MENTAL HEALTH

Name ______________________________

Date ______________________________

## Questionnaire

A. Basic School of Nursing

1. Name of School
2. Place
3. Dates attended

B. Other schools attended following high school

1. Type of program .
2. Degrees
3. Major for each degree
4. Year each degree was earned

C. Experience in school nursing

1. Undergraduate experience
    a. What course work did you have in school nursing?

    b. Was field practice included with the course work? Yes__ No__
    If "Yes" state the amount, kind and type of agency or institution.
2. Postgraduate courses
    a. What course work did you have in school nursing?

    b. Was field practice included with the course work?
    If "Yes" state the amount, kind and type of institution or agency.

3. Work experience you have had in school nursing
    a. Total years

    b. Grade levels (el., Jr.H.S., Sr.H.S.)

    c. Type of school (public, parochial)

4. Additional comments (if any)

D. Experience in psychiatric nursing

1. Undergraduate experience
    a. What course work did you have in psychiatric nursing?

    b. Was field practice included with the course work? Yes__ No__
       If "Yes" state the amount, kind and type of agency or institution.

2. Postgraduate courses
    a. What course work did you have in psychiatric nursing?

    b. Was field practice included with the course work? Yes__ No__
       If "Yes" state the amount, kind and type of institution or agency.

3. Work experience in psychiatric nursing
    a. Total years

    b. Type of agency

    c. Type of position held

4. Additional comments (if any)

E. Experience in public health nursing

1. Undergraduate experience
    a. What course work did you have in public health nursing?

    b. Was field practice included with the course work? Yes__ No _
       If "Yes" state the amount, kind or type of agency.

    c. Was this experience under the auspices of a hospital or college school of nursing?

2. Postgraduate courses
    a. What course work did you have in public health nursing?

    b. Was field practice included with course work? Yes__ No__
    If "Yes" state the amount, kind or type of agency.

3. Work experience in public health nursing
    a. Total years

    b. Type of agency

    c. Type of position held

4. Additional comments (if any)

F. Course work in nursing of children since earning your baccalaureate degree

1. What postgraduate work have you had in the area of nursing of children?

2. Was field practice included in the above course(s)? Yes__ No__
If "Yes" please state the amount and kind.

ECS/hjb

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
Department of Nursing Education

WORK CONFERENCE ON THE SCHOOL NURSE IN MENTAL HEALTH

## Job Description

Name ________________________________

Date ________________________________

I. Give a description of your job as it is carried out at present:

## JOB DESCRIPTION

2. Give a description of your job as you would like to see it carried out:

3. Describe the administrative structure under which you work. Draw a diagram if possible:

Work Conference on the School Nurse in Mental Health
WORKSHOP - 2
July through July , 196

## Progress Report

1. How has attendance at the workshop changed your participation in the mental health aspects of the school program?

2. In what ways has attendance at the workshop helped you in your activities with:

   a. Children:

   b. Parents:

   c. Teachers:

3. What unmet needs in the area of school mental health are you experiencing in your work situation?

4. How has the knowledge from the workshop helped you to plan for dealing with the present unmet needs?

5. What additional information do you feel is necessary in order to assist you in working more competently in the area of school mental health?

TEACHERS COLLEGE
COLUMBIA UNIVERSITY
NEW YORK, N. Y. 10027

## DIVISION OF NURSING EDUCATION

## Evaluation of the Workkshops on Mental Health for School Nurses

Please check off the column which you believe to best indicate the degree of influence that the workshop has had on your knowledge, understanding and abilities in the area of mental health and school nursing.

| ITEM | DEGREE OF INFLUENCE | | | | COMMENTS |
|---|---|---|---|---|---|
| | Great | Some | Little | None | |
| 1. Knowledge of growth and development | | | | | |
| 2. Ability to identify signs and symptoms of underlying emotional problems. | | | | | |
| 3. Knowledge of drugs used in treatment of emotional disturbances. | | | | | |
| 4. Knowledge of psychological and psychiatric terminology. | | | | | |
| 5. Ability to interview children and others. | | | | | |
| 6. Awareness of community resources. | | | | | |
| 7. Use of community resources for mental health & other problems. | | | | | |
| 8. Ability to assess more total needs of children. | | | | | |
| 9. Willingness to discuss emotional problems with parents, school staff, etc. | | | | | |
| 10. Ability to motivate parents and others to seek help with emotional problems. | | | | | |

# Evaluation of the Workshop Conferences on Mental Health for School Nurses

| ITEM | DEGREE OF INFLUENCE<br>Great | <br>Some | <br>Little | <br>None | COMMENTS |
|---|---|---|---|---|---|
| 11. Understanding of multiple factors which influence mental health and behavior. | | | | | |
| 12. Attitudes or feelings toward children and parents. | | | | | |
| 13. Interest in helping children and others with mental health problems. | | | | | |
| 14. Knowledge of trends and goals of community mental health programs. | | | | | |
| 15. Understanding of modern psychiatric concepts and practices. | | | | | |
| 16. Knowledge of communication theory - eg. verbal and non-verbal modes. | | | | | |
| 17. Knowledge of interpersonal theory. | | | | | |
| 18. Awareness of kinds of common crisis occurring in childhood which may affect the mental health of the child. | | | | | |
| 19. Understanding of family dynamics. | | | | | |
| 20. Ability to gather more accurate and complete health and developmental histories. | | | | | |
| 21. Awareness of attitudes of children, parents and others toward me. | | | | | |
| 22. Ability to plan the care of an individual or group of children. | | | | | |
| 23. Ability to teach in the health area. | | | | | |
| 24. Interpersonal relations with school personnel or others. | | | | | |
| 25. Ability to use a psychotherapeutic approach. | | | | | |
| 26. Ability to identify crisis situations involving children which may require intervention. | | | | | |

Evaluation of the Workshop Conferences on Mental Health for School Nurses

| ITEM | DEGREE OF INFLUENCE | | | | COMMENTS |
|---|---|---|---|---|---|
| | Great | Some | Little | None | |
| 27. Feelings of confidence in discussing mental health needs or problems. | | | | | |
| 28. Ability to interpret the mental health needs or problems of children to psychiatric and other specialists. | | | | | |
| 29. Ability to make referrals for psychiatric consultation. | | | | | |
| 30. Ability to use psychiatric or other mental health consultants to understand needs and behavior of children. | | | | | |
| 31. Ability to deal with home visits. | | | | | |
| 32. Ability to study and analyze own feelings and behavior toward others. | | | | | |
| 33. Personal growth and life. | | | | | |
| 34. Objectivity in approach to others. | | | | | |
| 35. More self confidence in dealing with emotional problems. | | | | | |
| 36. Ability to do more complete recordings. | | | | | |
| 37. Desire to work with school personnel on mental health needs of children | | | | | |
| 38. Understanding of roles and functions of the school nurse in mental health area. | | | | | |
| 39. Reading or using reference material on mental health and psychiatry. | | | | | |
| 40. Telephone contacts with parents. | | | | | |
| 41. Feelings toward parents of emotionally disturbed children. | | | | | |
| 42. Ability to work with staff of other community agencies on mental health problems and programs. | | | | | |

Evaluation of the Workshop Conferences on Mental Health for School Nurses

| ITEM | DEGREE OF INFLUENCE | | | | COMMENTS |
|---|---|---|---|---|---|
| | Great | Some | Little | None | |
| 43. Ability to interpret the goals and practices of the mental health field to families, school staff, etc. | | | | | |
| 44. Spending time with emotionally upset children and others. | | | | | |
| 45. Spending time with parents or other family members. | | | | | |
| 46. Desire to pursue more studies on mental health and other related areas in school nursing. | | | | | |
| 47. Relationships with the guidance counselor (s) in the schools. | | | | | |
| 48. Relationships with teachers in the school. | | | | | |
| 49. Relationships with principal (s) in the school. | | | | | |
| 50. Relationships with ________ in the school. (fill in this one) | | | | | |
| 51. Understanding of ways that school nurse can promote positive mental health in the school. | | | | | |
| 52. Ability to function as a team member with others on problems of children. | | | | | |
| 53. Understanding of unconscious motivation - determinants of behavior. | | | | | |
| 54. Relationships with superiors. | | | | | |
| 55. Knowledge of mental health principles and practices. | | | | | |
| 56. Ability to counsel children on problems. | | | | | |

Evaluation of the Workshop Conferences on Mental Health for School Nurses

| ITEM | DEGREE OF INFLUENCE<br>Great | Some | Little | None | COMMENTS |
|---|---|---|---|---|---|
| 57. Ability to counsel parents on problems and needs of children. | | | | | |
| 58. Ability to help teachers understand mental health needs and behavior of children. | | | | | |
| 59. Ability to help teachers understand own behavior and its effects on **children.** | | | | | |
| 60. Insight on your own attitude and behavior and its effects on children and others. | | | | | |

TEACHERS COLLEGE
COLUMBIA UNIVERSITY
NEW YORK, N. Y. 10027

Mental Health - School Nurse, Workshop # ________

## QUESTIONNAIRE - EXPECTATIONS

------

Please answer the following questions briefly and in outline form (numbering statements).

1. What areas do you hope will be explored in the work conference?

2. What do you expect to gain from this work conference in:

Knowledge and Understanding

Skill

Other

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
Department of Nursing Education

## WORK CONFERENCE ON THE SCHOOL NURSE IN MENTAL HEALTH

### Evaluation

Name ______________________

Date ______________________

1. What did you expect to gain from this conference?

2. Were your expectations met? Yes__ No__
   Please give the reasons for the above answer.

3. What recommendations do you have for changing and strengthening the content and the conduct of the conference? Include suggestions about the length of the course.

4. Other comments:

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
DIVISION OF NURSING EDUCATION
Work Conference on the School Nurse in Mental Health
Nurse-Patient Interaction

(UPPER SECTION)

Name ______________________

Date ______________________

Nurse's Reaction

To the assignment:
To the setting and personnel:
To the child:
Other reactions:

(LOWER SECTION)

Statements made by the Nurse, including reaction of her feelings toward the patient:

Statements made by the Patient, and nurse's observations of facial expression, tone of voice, body movements, and posture:

Nurse's Analysis of the interaction including hypotheses:

Instructor's Comments:

| Nurse | Patient | Analysis | Comments |
|---|---|---|---|
| | | | |

# Review Sheet for Process Recordings

## Initial contact

- Verbal
  - Enhance conversation
  - Cut off conversation
- Non-verbal
  - Observations recorded - posture, etc.
  - Tone of voice, etc. - use observation sheet

## Activities of the nurse

- What does she do?
- Why does she do it? (include relationship to the problem)

## In verbal exchange look for:

- Enhancing conversation
- Cutting off conversation
- Changing the subject
- Focusing on others than the student (mother, interviewer)
- Making suggestions
  - Kinds of . . .
- Asks a problem question
- Permits rambling
- Sets limits

## Under-involvment

## Over-involvement

## Fosters independence

## Termination

- Natural
- Abrupt
- Prolonged

TEACHERS COLLEGE, COLUMBIA UNIVERSITY

Work Conference of the School Nurse in Mental Health
July through July , 196

## Observation Guide

### Physical Appearance

Stature
Complexion
Posture (body language)
Grooming
Visible defects
Coordination

### Behavioral

Mien
Activities

### Verbal

Tone of voice
Language

### Non verbal other than above

Facial expression

### Means of communication other than verbal

Type of contact

### Observable relationships

Adults and peers

### Other

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
Division of Nursing Education

School Nurse Mental Health Workshop

## SITUATIONS

| | Satisfactory Yes or No | If "No" - Better answer and brief statement of reason. If "Yes" - why is the answer satisfactory. |
|---|---|---|
| 1.<br>Student: Why am I so different? I'm just no good.<br>Nurse: I think you are good, Todd, and very important to me. I consider you my friend. | | |
| 2.<br>S. Oh, I'd leave home, get an apartment and hang around the village.<br>N. If you drop out of high school you probably couldn't get a job that would pay enough for an apartment and food. | | |
| 3.<br>S. Oh, I feel sick to my stomach and I have cramps in my stomach.<br>N. What's the matter C., don't you like this school? | | |

| | Satisfactory Yes or No | In "No" - Better answer and brief statement of reason. If "Yes" - why is the answer satisfactory. |
|---|---|---|
| 4.<br>S. My mother doesn't like me.<br>N. But your mother does like you. | | |
| 5.<br>S. No, I don't like breakfast.<br>N. When you get home today you should have lots of liquids, etc. | | |
| 6.<br>S. I'll go back in there awhile and see if she has spelling or anything.<br>N. When did you comb your hair? | | |
| 7.<br>S. I'm stupid.<br>N. No, you are not stupid. I was talking with your teacher just yesterday and she told me that you are doing exceptionally good work in her class. | | |

| | Satisfactory Yes or No | If "No" - Better answer and brief statement of reason. If "Yes" - why is the answer satisfactory. |
|---|---|---|
| 3. | | |
| . How can I get that job? My teeth look so bad, will they hire me? | | |
| . You're right, Tony, we've talked teeth a long time - here is a list of a few dentists who will do work for our kids at special rates. | | |
| . | | |
| . Do you have many friends? | | |
| . Not too many. Just those that will go with me. | | |
| . How are things going in school? | | |
| 0. | | |
| . Daddy said he didn't think we needed help this year. | | |
| . That's fine, I'm glad he feels he doesn't - Will you have a Christmas tree? | | |

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
Division of Nursing Education

## Work Conference Materials Which Will Be Available In 539 Dodge Hall For The Use Of Workshop Participants

## BOOKS

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